S. HRG. 100-296, PT. 4

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1988

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

H.R. 3058

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES, FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1988, AND FOR OTHER PURPOSES

Part 4—(Pages 1–726)

Nondepartmental witnesses

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1988

THURSDAY, MAY 7, 1987

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:40 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Lawton Chiles (chairman) presiding.

Present: Senators Chiles, Burdick, and Hatfield.

NONDEPARTMENTAL WITNESSES

Senator CHILES. Good morning. The subcommittee will continue with public witnesses focusing on programs under the jurisdiction of the Department of Health and Human Services.

This week we are going to hear testimony from over 200 witnesses. And because of this large number of witnesses, we have to request that each of the witnesses keep their oral testimony brief.

Your full statement will be included in the record. And to help us stay on schedule, we use a procedure, when the red light goes on, we ask you if you would wind up your statement.

That means that the 3 minutes has expired. We need to do this so that everybody gets a fair opportunity. A number of you come from out of town, and we certainly want to have a chance to hear you.

The committee is pleased to have as its first witness today Dr. John Grupenhoff with the American Academy of Dermatology.

STATEMENT OF DR. JOHN T. GRUPENHOFF, AMERICAN ACADEMY OF DERMATOLOGY

Dr. GRUPENHOFF. Thank you, Mr. Chairman. I am here representing Dr. Peyton Weary, who is stuck in an airport in Charlottesville, and couldn't make it.

I will keep my remarks brief.

I represent the American Academy of Dermatology. The American Academy of Dermatology supports the call for the sum of $196 million for the National Institute of Arthritis, Musculoskeletal and Skin Diseases, and supports the ad hoc proposal of the committee for biomedical research of $7.6 million.

I would like to call your attention to the fact, Mr. Chairman, that after me there will be nine spokespersons for various dermatological diseases. This is quite a remarkable development over the last several years, that a number of organizations have come together about specific diseases in which they are concerned.

This is a new development, and it parallels the development that has occurred in the field of dermatological research, which is an outpouring of research results which give a great deal of hope to these consumer groups and patient advocacy groups.

Mr. Chairman, the Academy and all of the organizations involved with dermatological research, and all of the organizations which support the new Institute for Arthritis, Musculoskeletal and Skin Diseases support the concept this year of six core research centers for dermatological research at a cost of $2.5 million.

And contained within their overall proposal of $196 million is that $2.5 million. These core centers are supported because of that vast outpouring of information in the field of dermatological research that has occurred over the last decade, and also, because of the fact that all biomedical research has become so complex that many disciplines are involved, and core centers are necessary to carry this forward.

PREPARED STATEMENT

Mr. Chairman, I thank you on behalf of the Academy for the opportunity to appear.

Senator CHILES. Thank you very much, doctor.

[The statement follows:]

STATEMENT OF PEYTON E. WEARY, M.D., WASHINGTON REPRESENTATIVE, AMERICAN ACADEMY OF DERMATOLOGY, INC.

Mr. Chairman, I am Peyton E. Weary, M.D., Professor and Chairman of the Department of Dermatology at the University of Virginia School of Medicine and Washington Representative from the Council on Governmental Liaison of the American Academy of Dermatology. I am also a past Vice-President of the Society for Investigative Dermatology. I am presenting this testimony on behalf of the American Academy of Dermatology, whose membership of over 6,500 represents the majority of American Dermatologists, and on behalf of The Society of Investigative Dermatology, the representative organization for the dermatologic biomedical research community.

We are very grateful for the strong financial support provided by the Congress last year for the new National Institute of Arthritis and Musculoskeletal and Skin Diseases and applaud your recognition that, in order to assure success, a new institute requires careful nurturing. I am pleased to report that it is our perception that this new venture is off to a very good start under the able leadership of Dr. Lawrence Shulman and with the advice and assistance of an outstanding advisory council. The challenge, now, is to maintain, and, indeed, expand upon, this firm base so that the exciting research opportunities which exist in the three mandated areas reach fruition.

We are also grateful to you for refusing to accept the Office of Management and Budget proposal this year which would have "carried over" $339 million from NIH's fiscal year 1987 budget to fiscal year 1988. Your standing firm on this gives us all in the field of biomedical research a great sense of support.

Appended to this testimony is a recent article from the New York Times Magazine which clearly underlines the extraordinary advances in research on the skin and its afflictions that have taken place in the last 10-15 years (Appendix A). Implicit in this is the promise that the exponential increase in our understanding of basic physiologic and biochemical processes in the skin will lead to improved methods of treatment for many of the over 4000 different diseases of the skin which currently are recognized and, furthermore, will shed new light on many internal diseases since the same disordered metabolic processes may produce disease elsewhere in the body. We are particularly pleased that there is a close collaboration and increasing interdisciplinary research with our partners in this new institute which will greatly enhance the productivity of all.

I would also like to take this opportunity to remind the Subcommittee of the fact that our specialty of dermatology has also assumed a position of leadership in the area of prevention and early detection of disease as a result of sponsorship of over 400 skin cancer detection clinics nationwide each year during the past two years and that we hope to expand upon these initial efforts by creating a comprehensive, coordinated and sustained National Program for the Early Detection and Prevention of Malignant Melanoma and Other Skin Cancers over the next few years. To this end, the American Academy of Dermatology is sponsoring an Invitational Conference on May 1 in Washington to focus attention on the need for such a program which seems particularly appropriate at this time when we repeatedly hear about the predicted depletion of the ozone layer and its potential for increasing the threat of skin cancer (see appended Washington Post article, Appendix B).

Mr. Chairman, we have carefully reviewed the projected needs for FY 1988 for the National Institute of Arthritis and Musculoskeletal and Skin Diseases, and we support the level of funding of $196,008,000 proposed by the Coalition of Organizations Concerned with the Programs of National Institute of Arthritis and Musculoskeletal and Skin Diseases (Appendix C). It is projected by the Coalition that 40% of research grants could be funded at that level and, we believe, this is a reasonable and achievable level given the high quality of the grant requests submitted.

We were particularly pleased to note that the Coalition supported the creation of six new core centers for skin disease research and incorporated in the proposed budget a sum of 2.55 million dollars to establish these centers. At present, no core centers exist for dermatological disease. We submit justification for these centers as an appendix to this testimony (Appendix D). I have appended testimony related to the importance of these centers for dermatology. We are also supportive of the need to conduct two clinical trials in skin diseases, one of which deals with epidermolysis bullosa, a disease of which you are well aware. The other clinical trial relates to another inherited skin disorder, ichthyosis, which causes significant problems for a large number of individuals in this country. We believe the opportunities for significant advances in dermatologic research are so great as to clearly justify these new initiatives.

In addition, as we have in the past, we strongly support substantial increases in funding for the National Cancer Institute in which the outstanding Dermatology Intramural Research Program resides. This is particularly important at this time when the threat of a substantial increase in the prevalence of skin cancer and, in particular, malignant melanoma looms so large on the horizon. We are greatly concerned about the exponential increase in malignant melanoma in recent years and the large number of patients who die yearly from this very agressive type of cancer. We, furthermore, suggest that a major increase in funding for the National Institute of Environmental Health Sciences and the National Institute for Occupational Safety and Health are entirely justified to deal with the impact of the ozone depletion and concomitantly a major increase in sunlight exposure and the injurious effects this will have upon the skin.

The threat of AIDS is of great concern to dermatologists since many of the most serious consequences of this dreaded disease are skin-related. We know the Congress is concerned about this and we would strongly encourage a major increase in funding for the National Institute of Allergy and Infectious Diseases to help address this epidemic.

We also have substantial research interests in problems of the elderly, many of whose major complaints are skin related. Some excellent research is already being conducted by dermatologists supported by the National Institute for Aging but much remains to be accomplished and this Institute also deserves your generous support.

Finally, Mr. Chairman, we support overall the recommendations of the Ad Hoc Group for Medical Research Funding.

In conclusion, Mr. Chairman, we wish to express our continuing admiration for the work of this Subcommittee and for their enduring support for biomedical research. It would appear to us that this year, which celebrates the founding of the National Institutes of Health, should also serve as a tribute to the Congress which has expressed its enlightened interest by providing the support to make it all possible. This partnership between the

Congress and the National Institutes of Health has clearly been one of the most productive in the history of mankind and you deserve to be proud of your role in it.

Thank you for the opportunity to testify once again.

(Appendix A and B are in subcommittee files.)

Appendix C

NATIONAL INSTITUTE OF ARTHRITIS, MUSCULOSKELETAL AND SKIN DISEASES

IN THOUSANDS

	1986		1987		1988 Coalition	
	No.	Amount	No.	Amount	No.	Amount
Research Grants						
Non Competing	392	$53,346	414	$66,595	421	$75,139
Supplemental		417				400
Competing	199	26,371	179	27,941	320	54,038*
	591	80,134	593	94,536	741	129,577
Research Centers: Spec/Comp	14	9,354	23	18,170	30	27,167
Other Research	69	5,273	70	5,634	99	8,256
Training	223	5,812	280	6,433	375	9,495
R&D Contracts	10	2,339	7	3,327		6,192
Intramural		7,500		6,883		10,321
Management & Support		2,854		3 730		5,000
TOTAL	907	$113,266	973	$138,713	1,245	$196,008

* At this level the Institute will fund approximately 40% of the study section approved grants.

FY 1988 Initiatives

Research Project Grants

- Increasing evidence points to a role for infectious agents in early arthritis.
- Research has determined that osteoarthritis is not necessarily a wear-and-tear disease nor an inevitable consequence of aging. Multidisciplinary studies on osteoarthritis are being planned as a result of a major workshop in this area held in FY 1986. The workshop proceedings have just been published in the December issue of the Journal of Rheumatology. The recommendations of this workshop will provide the basis for a research solicitation to encourage

studies on the pathogenetic mechanism in osteoarthritis, to promote epidemiological research studies, and to encourage interdisciplinary investigations.

- Researchers are now learning more about the importance of estrogen, calcium, and exercise in osteoporosis, a major crippling disorder responsible for most of the bone fractures in the elderly. Studies are planned to more fully discern the role of hormones, nutrition, and exercise in treating and preventing this serious disorder.

- Productive research has resulted in increased survivability of patients with systemic lupus erythematosus. However, much remains to be learned about this important serious disease of young women. Investigations to be pursued include research on cross-matching antibodies indicating that lupus may be triggered by environmental antigens, as well as autoantigens; research on immunogenetic determinants; and innovative approaches for immunologic intervention and treatment.

- New, diverse pharmacologic agents have shown great promise in correcting the vascular pathology of Raynaud's phenomenon and systemic sclerosis (scleroderma). At the coalition budget level, a number of research avenues would be followed, including important basic research on microvascular, connective tissue and immunologic abnormalities that characterize Raynaud's phenomenon and scleroderma, as well as mechanisms of action of pharmacologic agents being developed for their treatment.

- Basic research has provided much information on the physiology and pathophysiology of muscles. Additional fundamental research will be encouraged on the structure and function of muscle; this can then be applied to further understanding of muscular diseases and can suggest possible therapeutic approaches.

- Basic studies of muscles, tendons, and ligaments will enable development of improved athletic training programs and optimal rehabilitation programs. Expanded efforts in such basic research studies and their application in athletes, the public at large, and patients are planned.

- The Institute has stimulated interest among the research community in research on low back pain, the most common cause of limitation of activity among persons 17 to 45 years of age. New, multidisciplinary research directions will be pursued on the etiology and treatment of low back pain.

- Recent research discoveries, utilizing monoclonal antibodies, have pinpointed the precise location of cutaneous disease injury responsible for severe blistering of the skin in such tragic, debilitating diseases, as epidermolysis bullosa and pemphigus.

- Recent dermatologic research has now established that the skin is actively involved in immunologic reactions of vital importance, not only for several skin diseases such as contact dermatitis, but also in immune regulation in the body as a whole.

Centers

Many important research advances have been reported by the Multipurpose Arthritis Centers, including development of an excellent new animal model for osteoarthritis; determination of the efficacy of low dose methotrexate in treating severe refractory rheumatoid arthritis; finding that running may not be a risk factor for osteoarthritis; and the potential usefulness of lymphoid irradiation therapy for severe rheumatoid arthritis.

Under the coalition budget, 9 Specialized Centers of Research (SCORs) in arthritis and musculoskeletal diseases, would be continued for $8.1 million. SCORs provide a highly effective means of concentrating research efforts on high priority rheumatic diseases of national importance. These Specialized Centers will conduct needed coordinated basic and clinical research in major disease areas such as osteoarthritis, rheumatoid arthritis, and osteoporosis.

Six new core centers in skin diseases research would be initiated under the coalition budget level ($2.55 million).

Other Research

Careers: Well-trained investigators are vital to fully exploring the important basic and clinical research opportunities available for this new Institute. If these indepth training programs are not appropriately funded, young researchers will be deprived of essential advanced research training opportunities at a critical point in their development; and as a result, may not make the transition to fully independent and productive senior investigators.

Recognizing the great importance of providing these research career development opportunities, the coalition budget would increase the number of competing career awards.

Research Training

The creation of this new Institute at the NIH offers possibilities for greatly expanded research training opportunities in a wide variety of important diseases within the mission of the Institute. Under the coalition budget level, a more complete training program could be encouraged and sustained, with an additional 100 slots (20 individual and 80 institutional).

Contracts

There is a critical need for valid epidemiologic data on important diseases within the NIAMS mission. Epidemiology research contracts studying arthritic diseases in the U.S. would be supported at $2 million under the professional judgement budget. Examples of these epidemiological studies include analyses of existing national longitudinal data on arthritis, musculoskeletal and skin diseases, as well as detailed information on the spine; and analyses of data from the third Health and Nutrition Examination Survey (NHANES III), conducted by the National Center for Health Statistics. This survey will include an extensive section on arthritis and musculoskeletal disorders and bone density studies of osteoporosis.

Three contracts related to osteoporosis in the areas of bone density measurements, functional assessment of knee stability, and reduction of osteoporosis with fluoride in drinking water are provided for in the coalition budget.

Also included in the coalition budget level are two clinical trials in skin diseases: (1) Epidermolysis Bullosa: Efficacy of Dilantin and Treatment of Esophageal Strictures; and (2) the

Efficacy of 13-cis Retinoic Acid in Treating Keratinizing Disorders.

Multicenter clinical studies in rheumatic diseases would also be supported; and important, previously recommended, clinical trials in serious connective tissue diseases would be initiated.

Intramural

Intramural research activities in the NIAMS provided many examples of outstanding investigations in the basic and clinical sciences, leading to important advances in medicine. Research accomplishments have been reported from NIAMS intramural laboratories in understanding rheumatoid arthritis, systemic lupus erythematosus, and other types of arthritis, connective tissue disorders; cellular and chemical immunity; underlying processes that produce autoimmunity and the role of autoimmunity in disease; development of inflammation and its role in disease; and structure and function of muscles. Progress in all of these areas is based on multifaceted approaches involving experts in immunology, biochemistry, molecular biology, genetics, and biophysics.

The development of highly productive intramural orthopaedics research activities has been an objective of the NIH for several years. Appropriate, highly capable research personnel have been recently recruited and trained, and are now available for initiating this program. This is a unique research undertaking at the NIH and a strong addition to the research portfolio of the NIAMS.

At the coalition level, it will be possible to plan for new research activities in dermatology.

Research Management and Support

Creation of the new National Institute of Arthritis and Musculoskeletal and Skin Diseases has set in motion a three-year effort to establish a fully functioning independent organization. More than 12 new FTEs have been assigned to the new Institute. Additional new positions and appropriate funds are needed to setup a minimal structure of central administrative functions to serve the extramural programs and intramural research program which have already been transferred to the new Institute.

Appendix D

CORE CENTERS FOR DERMATOLOGY

Organized Dermatology, concerned citizens and the entire investigative constituency of the National Institute of Arthritis, Neuromuscular and Skin Disease urges the Congress to fund 6 Core centers for dermatological research at a cost of 2.55 million dollars in the federal budget for 1988. These Core centers will greatly enhance the productivity of dermatological research and facilitate translation of research discoveries into better patient care and treatment. Furthermore the centers will increase interchange between dermatological investigators and the remainder of the biomedical community; new information developed by dermatological investigators can then be exploited by other biomedical investigators in such diverse areas as rheumatology, infectious disease, cell biology and cancer.

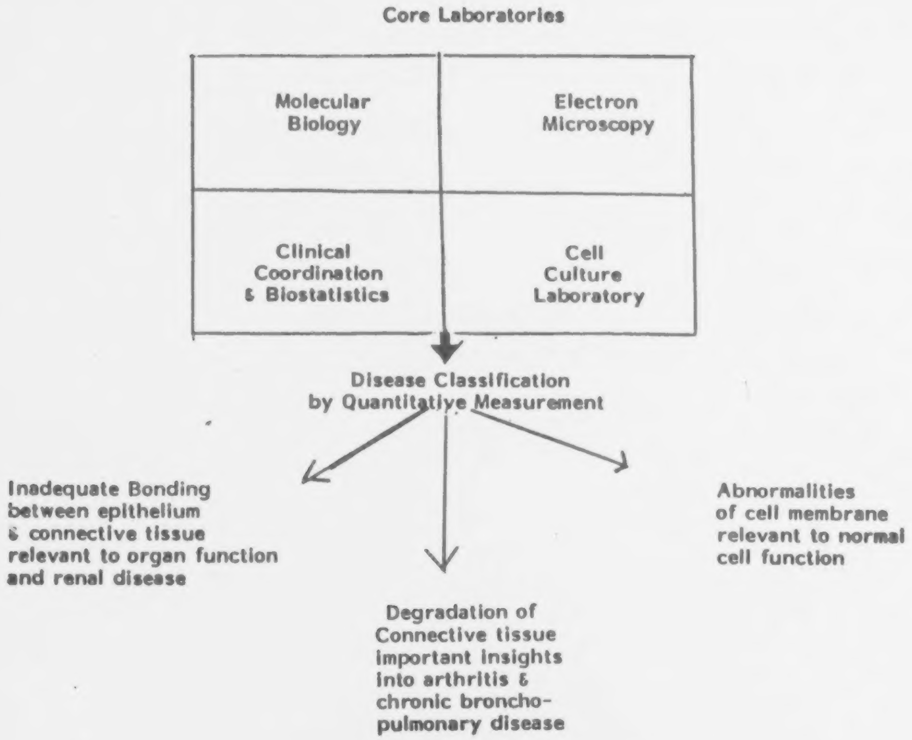
The impact of dermatological disease to American citizens is staggering. One-eighth of all people (22.9 million) have a skin complaint, of which 18.8 million have cutaneous problems which are considered serious. Of the total of 556 million office visits made in 1979, 63 million were for a skin problem. This makes skin disease the fourth most common patient complaint. In 1978 there were 9000 deaths from skin disease. The economic impact of skin disease is enormous. Two per cent of the total national health expenditure is for skin problems. In 1981 this involved the expenditure of 5.1 billion dollars. When the estimated morbidity loss from skin disease (1.5 billion dollars) and mortality loss (200 million dollars) is added, the bill for dermatological disease in the United States is 6.8 billion dollars. These figures do not adequately represent the human toll. Loss of function, discomfort, disfigurement and destruction of self image cannot be measured in dollars.

Dermatological investigation over the past twenty years has reached maturity. The most sophisticated tools of immunobiology have been used to study inflammation in general, eczema, allergic reactions, lymphoma, vitiligo, and of course AIDS. The most sophisticated tools of modern biochemistry have been utilized to study aging and mechanisms of tissue destruction; contributions by dermatologists from this area have been very important in understanding the joint destruction in arthritis. Cell biology has provided insights into cell kinetics and cell behavior pertinent to psoriasis and cancer. Finally, the new discipline of molecular biology has found broad application in Dermatology. Studies of genetic control in epidermolysis bullosa, ichthyosis, and skin cancer have provided unique insights for all of Medicine.

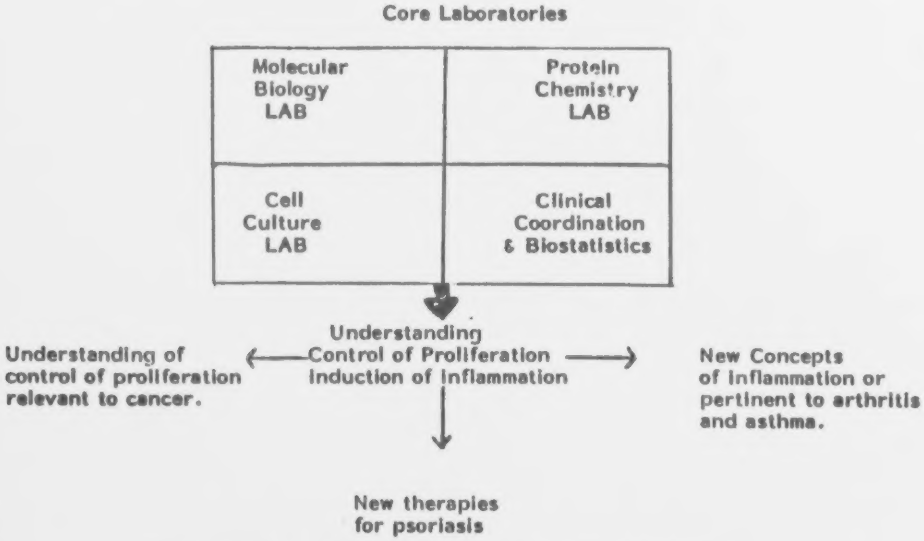
These advancements have led to direct improvements in patient care. Dermatological investigation has led to the development of retinoids for acne, psoriasis and malignant skin disease. Photochemotherapy (PUVA) has provided a unique therapy for psoriasis and pointed the way for the use of light and pharmaceutical agents in the treatment of a wide spectrum of diseases including photophoresis for cutaneous helper T cell lymphoma. Much of the laser technology now presently employed has been developed by dermatologists. Dermatology has focussed the use of corticosteroids in inflammatory disease and defined new therapeutic modalities for the use of these drugs. The importance of skin disease in AIDS has resulted in fundamental immunological, biological and molecular genetic discoveries.

Investigative Medicine needs to establish six Core centers for fundamental cutaneous biological research. These centers, established in programs of great excellence, will provide Core facilities where costly, cutting edge, investigative technology can be brought to bear on a variety of clinical pertinent challenges. Core centers will guarantee maximum utilization of expensive technologies to benefit large numbers of committed investigators. As important the centers will be magnets for interaction between basic biomedical investigators from a variety of disciplines and disease oriented clinical investigators. Core centers will be a shared resource for the investigation of all of the dermatological diseases which have concerned citizen groups e.g. epidermolysis bullosa, icthyosis psoriasis etc. Core centers will have an impact not only on Dermatology but all investigative Medicine. Information will be transmitted to rheumatologists, oncologists, immunologists, infectious disease specialists, so that advances made in Dermatology can have broad impact on the fight against all diseases. The ability of the Core centers to seed preliminary studies will lead to data which can generate peer review research proposals and thus provide new initiatives in the conquest of disease.

The establishment of Core centers for Dermatology in the newly established Institute of Arthritis, Neuromucular and Skin Disease will ensure that all the constituencies of the institute can make major contributions through the center's program.


Core Laboratories
Molecular Biology
Electron Microscopy
Clinical Coordination & Biostatistics
Cell Culture Laboratory
Disease Classification by Quantitative Measurement
Inadequate Bonding between epithelium & connective tissue relevant to organ function and renal disease
Abnormalities of cell membrane relevant to normal cell function
Degradation of Connective tissue important insights into arthritis & chronic broncho-pulmonary disease

The use of highly specialized core laboratories to investigate the genetic disease Epidermolysis Bullosa - Interactions and Impact. The results of investigation and implications are based on results already published.


Core Laboratories
Molecular Biology LAB
Protein Chemistry LAB
Cell Culture LAB
Clinical Coordination & Biostatistics
Understanding Control of Proliferation Induction of Inflammation
Understanding of control of proliferation relevant to cancer.
New Concepts of Inflammation or pertinent to arthritis and asthma.
New therapies for psoriasis

The use of specialized high technology core laboratories to investigate psoriasis - Interactions and Impact. The results of investigation and implications are based on results already published.

STATEMENT OF WILL WACHTEL, NATIONAL PSORIASIS FOUNDATION

Senator CHILES. Now we will hear from Mr. Will Wachtel of the National Psoriasis Foundation.

Senator Hatfield hoped to be here this morning, but he is not able to be here. He wanted to ask me to extend his personal welcome to you.

Mr. WACHTEL. Thank you, sir.

Mr. Chairman and members of the subcommittee.

My name is Will Wachtel, and I am age 34, and I have had psoriasis since I was 17. I am here on behalf of the National Psoriasis Foundation, and we are here to request funding for the National Institute of Arthritis, Musculoskeletal and Skin Diseases at a level of at least $196 million, including the $2.5 million that Mr. Grupenhoff mentioned for the six core centers.

We believe that this amount is crucial to continuing the significant progress of the Institute, and toward an eventual cure of psoriasis.

Very simply characterized, psoriasis is a condition where skin cells overproduce, and they multiply so fast that they cannot be shed. And therefore you have lesions that build up, reddish in appearance, often, covered in scale.

About somewhere in the estimate of 3 to 8 million Americans have this disease, which translates to about 1 in every 30 to 80 people.

And the extent of psoriasis in individuals can range from being minimal to so severe as to be functionally disabling and even life threatening in some cases.

And since both the severity and duration of bodily coverage can vary so widely, it is safe to say that the only thing predictable about psoriasis is that it is unpredictable.

And I can testify from my own experience that the psychological effects can be devastating. In fact, in most cases, the emotional impact is more of an impediment than the physical impact.

Since psoriasis is visible, and the skin is the means by which we initially define ourselves to others, coupled with the fact that we live in a society that places a high value on unflawed physical appearance, this affects one's acceptance by others, which also leads to problems with self-acceptance, which is so crucial in coping with this disease.

For myself, I feel I have made a lot of progress in coping, and mainly coming to a positive self image and overcoming self-imposed limitations.

However, there are still areas that I still have problems with such as public swimming or sunbathing. Also, dating has been a very hard thing for me to follow through with because of this disease.

And compounding this is the fact that not a lot of the public knows that psoriasis is neither contagious nor curable. And this leads some people with psoriasis to isolate themselves and even contemplate suicide.

I have not felt that desperate myself, but I know at least two people who have considered suicide as a way to end their anguish.

So can you imagine the effect on a child or adolescent who develops this disease? That thought bothers me rather greatly.

But thanks to your previous support of NIH, the main catalyst of psoriasis research in the United States, substantial progress in treatment of this disorder has been made.

One of NIH's successes was in developing a therapy called PUVA, now a widely used effective treatment. This is significant, because recently, a modified version of this treatment has been used to treat white blood cell lymphoma, a cancer which destroys the immune system.

This treatment was devised by a dermatologist, and has yielded promising results so far, while generating new clues to immune system mechanisms, clues that could lead to advances in both research and treatment of both cancer and AIDS.

So maximum funding of NIAMS can and does lead to knowledge that benefits the greater public in ways that are not always foreseen.

Additionally it sends a message to students that the Nation will continue to promote science, and that the students can foster a career in biomedical research.

Therefore, we are asking you to appropriate a minimum of the $196 million to this still young Institute.

I really would like to strongly emphasize the $2.55 million for the six core centers. They will be multidisciplinary in their research. And it will be beneficial in three ways.

One, it will employ people. Two, it will lead to knowledge that is applicable to other areas of medicine. And three, it will lead to knowledge that will help people to get off of government support and become taxpaying citizens.

Thank you for consideration of our request. You can rest assured that your backing has made a difference, and will continue to make a difference, in the lives of those of us afflicted with psoriasis.

PREPARED STATEMENT

Senator CHILES. Thank you very much. We appreciate your testimony here today.

Mr. WACHTEL. Thank you.

[The statement follows:]

STATEMENT OF WILL WACHTEL

My name is Will Wachtel. I am 34 years old and I have had psoriasis since I was 17. I am here today as a volunteer on behalf of the National Psoriasis Foundation to request funding for the National Institute of Arthritis, Musculoskeletal and Skin Diseases at a level of at least $196,000,000. We believe that this amount is crucial in continuing the significant progress of this Institute and to spur new discoveries in basic research.

Expressing it in simple terms, psoriasis is a disease where the skin cells overproduce. The skin cells multiply so fast that they can not be shed at the same pace, resultuing in elevated lesions which appear reddish and are often covered with scales.

It is estimated that 3 to 8 million Americans are afflicted with psoriasis, meaning that 1 person in every 30 to 80 suffers from the consequences of this disorder. The extent of psoriasis in individuals can range from being minimal to so severe as to be functionally disabling and even life-threatening in some cases. And since both the severity and duration of bodily coverage can vary so widely, it is safe to say that the only thing predictable about psoriasis is that it is unpredictable.

One thing that I can tell you is that psoriasis causes devastating psychological effects. In fact, in the majority of cases, the emotional impact is more of an impediment than the physical impact. Because psoriasis is visible and since our skin is the means by which we initially define ourselves to others, coupled with the fact that we live in a society that places a high value on unflawed physical appearance, people with this affliction feel anxious about their acceptance by others. Of course, this hinders one's self-acceptance, that attribute being so vital to effectively coping with this disease.

For myself, it is only in the last several years that I have learned to overlook people's stares and to focus on a positive self-image and to overcome self-imposed limitations. Though I feel I have made tremendous progress, there are still activities that I avoid, like swimming or sunbathing in public. Also, it has been a challenge to develop a dating routine and I am still struggling with this issue.

Compounding these concerns and the feeling of being different is the fact that much of the public does not know that psoriasis is neither contagious nor curable; this leads some psoriatics to isolate themselves and to even contemplate suicide. Though I have not felt that desperate, I know at least two people who have seriously considered suicide as a way to end their anguish. So can you imagine the effect upon a child or adolescent who develops this disease? That thought bothers me immensely.

However, thanks to your previous support of N.I.H., which is the main catalyst of psoriasis research in the U.S., substantial progress has been made in the treatment of this disorder and toward an eventual cure. One of N.I.H's successes was in developing a therapy called PUVA, now a widely-used effective treatment. Recently, a modified version of this treatment has been used experimentally to treat white blood cell lymphoma, a cancer which destroys the immune system. This treatment was devised by a dermatologist and it has yielded promising results so far while generating new clues to immune system mechanisms, clues that could lead to advances in both research and treatment of cancer and AIDS.

So maximum funding of NIAM can and does lead to knowledge that benefits the greater public in ways that are not always foreseen. Additionally, it send a message to students that the nation will continue to promote science and that they can foster a career in biomedical research. Therefore, we are asking you to appropriate a minimum of $196,000,000 to this still-young Institute.

Thank you for your consideration of our request. Rest assured that your backing has made and can continue to make a difference in the lives of those of us who have suffered from the effects of psoriasis.

STATEMENT OF VICTOR LLOYD, NATIONAL ALOPECIA AREATA FOUNDATION

Senator CHILES. Now we will hear from Mr. Victor Lloyd, National Alopecia Areata Foundation.

Mr. LLOYD. Thank you, Mr. Chairman. I am Victor Lloyd. I am with the local support group of the National Alopecia Areata Foundation.

We are here, of course, to support, to urge you to fund the full $196 million for NIAMS which earmarks $2.55 million for the six dermatological basic research centers.

Alopecia Areata means hairlessness. It afflicts people in different ways. Some get just a small patch of hairlessness in the middle of their head or on their chin or wherever.

Others are completely hairless, have absolutely no body hair whatsoever. It is a funny condition. It is only 1 of approximately 4,000 known dermatological conditions. It can affect anyone.

It affects, in fact, 1 out of 100 people in our population, as far as anyone can tell. Which means that you, that any of us here, know at least one person who has had alopecia, or will have it, have it now.

It can appear at any time, any age, to anybody, any ethnic background. It can appear suddenly. It can go away as suddenly, or it can last a lifetime.

My daughter has it. She lost all the hair on her head within a period of about 2 weeks when she was 8 years old. She is now 14, and she is bald as a nut; wears a wig.

She has learned—fortunately, she wears a wig. She has learned to put up with taunts from her peers at school; learned to put up with remarkable stupidity and insensitivity on the part of teachers. But she manages.

She manages rather well, as a matter of fact. She manages better than a great many other alopecia patients.

She does wear her wig. The only time she has trouble is when the thing falls off, as it will do from time to time, in the middle of a soccer field; and she gets very upset.

It has affected other people in more serious ways. My daughter just gets upset. Some people with alopecia have had very serious drug and alcohol problems.

It is really the psychological effect of this disease. It is nonfatal. It is slightly disfiguring. Because it is nonfatal and only slightly disfiguring, it has been very hard to find people interested in giving money for research for it.

We turn to you. As it turns out, what is fairly close, we are fairly close to getting a good understanding of the disease, of the condition.

It seems to be an autoimmune syndrome. Unlike male pattern baldness, the hair follicles remain active. And what happens is that the body tends to attack the hair shaft as it forms in the follicle.

So the feeling is at this point that if something can be found to turn off that mechanism, then the hair can continue to grow normally.

PREPARED STATEMENT

We are close. We really are fairly close. And it needs a push. It needs help. And we urge you to give the support we need.

Thank you.

Senator CHILES. Thank you very much, sir.

[The statement follows:]

STATEMENT OF VICTOR LLOYD

Mr. Chairman, I am Victor Lloyd and I am a representative of the local Support Group chapter of the National Alopecia Areata Foundation. I regret that Ms. Vicki Kalabokes, the Executive Director of the Foudation is not able to appear here before you, but she was unable to attend.

The National Alopecia Areata Foundation and the thousands of Alopecia Areata Support Group members nationwide want to thank you for your vital support last year toward the formation of the new Institute of Arthritis and Musculoskeletal and Skin Diseases(NIAMS). The Institute is an important step in the long process of finding cures and treatments to a large number of diseases, and we are grateful for the evident interest shown by you and your colleagues to strike at the many disfiguring, crippling, and fatal diseases that afflict so many Americans.

Alopecia Areata is only one of a great many ailments that has the attention of the Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). Alopecia Areata is a non-fatal and somewhat disfiguring disease that affects approximately one out of every one hundred people in this country. It is therefore probable that each of you knows at least one person who has the condition, has had it, or will have it at some point in their lives. The condition is characterized by loss of hair over a part or all of the body. The condition may come and go in a matter of a few months, or in the other extreme, may last a lifetime. Alopecia Areata is unpredictable in its randomness throughout the population: it occurs to young and old, black and white, men and women, rich and poor.

Although some researchers feel there is an occasional

hereditary factor in its appearance, this finding is by no means universal or conclusive. There is still no way of determining who it will strike, or when. There is also some research that indicates a correlation between asthma patients and Alopecia Areata victims. However there are also a very large number of victims of this ailment who are otherwise perfectly healthy.

Some Alopecia Areata patients have found that their hair loss was restored quite on its own within months or years of the original loss. Other patients lose their hair and it never grows back. I have a friend who lost all the hair on his head within a period of a few days when he was in his early twenties. In his early thirties all his hair grew back. Last year, aged fifty-eight, he lost all his hair agian in a period of about a week.

Unlike male pattern baldness, the follicles that produce hair shafts in the skin and scalp remain active in Alopecia Areata patients. The most recent and most reliable medical research seems to agree that Alopecia Areata is an auto-immune syndrome where the patient's body, for no known reason attacks and destroys the hair filament as it begins to form in the follicle.

Although Alopecia Areata is not a fatal or crippling disease, it is an ailment that does great harm to its' sufferers. Patients have hidden themselves in their homes upon finding that they have the disease, and never come out. **All Alopecia Areata patients with fairly extensive hair loss have suffered deep and irreparable psychological damage because of the effects of this disorder.**

The sad tales of the victims of this condition are legion. Children have been taunted by their peers or made to

suffer still more from the ignorance and insensitivity of their teachers and school officials. Adolescents and young adults have suffered great loneliness and anxiety because of a poor self-image that is the direct result of this disfiguring disease. Adults have found close friends and acquaintances no longer even recognised them following the loss of their hair. Older people have wondered if this is some other and terrible effect of the aging process.

And worse. Doctors who have, through their own ignorance, told patients that the condition is really just a result of stress or anxiety. People who, upon the loss of some or all of their hair became convinced that this was some special punishment visited upon them by a wrathful God and due to some real or imagined sin. Young people who lost their hair who then sought solace from their grief and anxiety in an abuse of drugs or alcohol.

The real horror lies in the fact that in our society there is such a strong emphasis on appearance. Many Alopecia Areata patients feel ashamed of their condition. Even discounting those who do not even seek medical assistance or explanation, most of the victims of this condition do not even look for and speak to other Alopecia Areata victims. We are convinced that more active research into the causes and possible cures to this strange but common ailment would help all those who have the condition. This would be true even if it were to take ten or fifteen years to find a cure.

I have already expressed to you our gratitude for the funding last year of the new Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). It is a strong thrust in the right direction for patients of Alopecia Areata and some 4,000 other recognized skin diseases and disorders.

This year we urge you to support the funding of the Institute with a full $196,000,000 budget which earmarks $2.55 million for six dermatology (basic research) centers. We are certain that such an effort will go a long way toward the time when Alopecia Areata will be a fully treatable condition. It is crucially important to assure that everyone be healthy enough psychologically and physically to be able to contribute to the welfare of our country.

STATEMENT OF MAJ. ALLAN CARROLL, FOUNDATION FOR ICHTHYOSIS AND RELATED SKIN TYPES, INC.

ACCOMPANIED BY MRS. DONNALL CARROLL

Senator CHILES. Now we will hear from Maj. Allan Carroll of the Foundation for Ichthyosis and Related Skin Types.

Major CARROLL. Mr. Chairman and members of the committee, good morning.

I am Maj. Allan Carroll of the U.S. Army Corps of Engineers, and I am the father of a little girl with ichthyosis.

I am presenting this testimony today as a volunteer, and as a concerned parent, on behalf of the Foundation for Ichthythosis and Related Skin Types.

We have all heard the saying that beauty is only skin deep. And for those of us with skin diseases, this is unfortunate.

My daughter has a skin disease called ichthyosis. It is called the fish scale disease, and it is not pretty. Just to give you an example, her skin reproduces itself very, very quickly, and I have to comb skin out of her hair and peel it off her body.

But I pull off scales from her hair that are the size of the old sized silver dollar, which are very thick, and it is painful to pull through her scalp.

When she was born, she was taken like normal babies to an area to be warmed and cleaned, and within minutes, the doctor returned to us and said, hey, I do not know what is happening. Your daughter, wherever she moves, her skin is cracking and bleeding, and I have never seen anything like this. I am looking in my medical books and stuff, and he said, I am calling around. But we are going to have to get her out of here.

So they sent her down to Denver's Children's Hospital, and she had excellent care. And because of the super care that she did have, she did not develop any kind of an infection. And as a result, like many infants do, she did not die.

But many infants do die as a result of the infection alone. Many are deformed for life.

We were then excited—I was at that time in South Dakota to be reassigned here to Washington because of all the tremendous medical and health facilities here.

But what was really odd was when we took her to the best places here that I had ever dreamed about and been advised about, they had never seen it. It is so rare that they had not seen it, and so all they could do was kind of suggest things, and it was a trial and error approach.

I know that your job of allocating finite resources to a seemingly infinite budget must be an awesome task. And I appreciate the opportunity to testify before you on my daughter's behalf, and all those other many innocent victims of this genetically transmitted defect.

And I request that favorable consideration be given to the proposed $196 million budget, and then that which is included for the six core research centers and then clinical trials.

And I would like to have my wife speak a little bit more on some of her impacts on this.

Senator CHILES. Fine. How old is your little girl now?

Mrs. CARROLL. She is 4 years old, almost 5.

I am Mrs. Donna Carroll, and we were asked to bring our daughter this morning, or at least to consider it, and we chose not to.

Being only 4 years old, she really does not realize now that she is different. That is just coming to her attention. In fact, all of this is quite normal for Heather.

She thinks that it is normal to go to a doctor every week. It has been interesting, in the military we go to different hospitals all the time, and each new doctor asks, what can we do for you? Because they very rarely have seen this, or there is very little written on the books, so we tell them what to do for Heather.

It is normal for her to put cream on her entire body twice a day with an acid in it that burns. And until she was 3 months, she could not hear, because her ear canals were totally occluded.

Now her ears are cleaned out once a week by an ENT doctor because of infections.

I see our time is up. Let me just briefly say that this has not been easy for our daughter. Her eyes are checked for cataracts and for drying, and she cannot close her eyes all the way.

And there are many traumatic things she goes through.

And we would just like you to consider the proposal for the budget so that perhaps this will not be so traumatic for other children and parents in the future.

Thank you.

PREPARED STATEMENT

Senator CHILES. We thank you both very much for coming, and we appreciate your testimony.

[The statement follows:]

STATEMENT OF MAJOR ALLAN CARROLL

I am Major Allan Carroll, of the United States Army Corp of Engineers, and the father of a little girl with ichthyosis. I am presenting this testimony today as a volunteer and concerned parent on behalf of the Foundation for Ichthyosis and Related Skin Types.

Today, there are tens of thousands of people with over two dozen kinds of ichthyosis living in our country. Worse, though, is the fact that there will be untold thousands more born into this world in the future with twisted, broken or missing skin genes, condemned to struggle every day of their lives with ichthyosis, and then to pass it on to their children and grandchildren, until the causes and cures of this genetic tragedy are found, and it can be eradicated for all time.

Ichthyosis, sometimes called "the fish scale disease," is a disorder of cornification of the skin surface. The tiny skin cells of the outer skin layer clump together and refuse to release from the surface of the skin. They build up into thick, leathery, rigid, discolored plates and ridges. Skin growth is out of control. The scales may block hair growth and perspiration. Body temperature control is disrupted; hearing may be blocked. Eyelids may be drawn so tight and dry that the eyes cannot ever close, even in sleep. Infections are common and almost uncontrollable, often accompanied by embarrassing odor.

Babies may be born encased in a parchment-like envelope that hardens and cracks as it dries after birth. Others are born so blistered and raw that even experienced doctors and nurses gasp, then whisper prayers for the tiny new life. Some of these children die in infancy. Others may live, only to learn that every doctor has heard of ichthyosis, but few have ever seen a case. It is often mentioned in textbooks, but without any adequate explanation of a cause or effective cure.

Today in America there are thousands of people disfigured by ichthyosis who hide from the sun, from society, from their families and even from themselves. It hurts them just to move within their parched and brittle dry skin. Most will probably never meet another person afflicted with the same disease, and will spend their lives feeling they are unaccepted, fatally flawed, failures.

For over two thousand years, since Hippocrates first described ichthyosis in Western medical literature, there was no hope for patients and families marked by this disease. Cause and treatment were mysteries and myths. At least one little girl known to the Foundation was reportedly kept locked in a closet for years by parents who saw in her dark leathery scales and pathetic disfigurement the mark of the devil's work. Ichthyosis wastes and breaks lives and dreams, suffocating them in ignorance, shame, and fear.

But this institution, the Congress of the United States, the highest expression of the spirit of the AMerican people, has started to change all of that. Money provided by this Committee has funded the new National Institute of Arthritis, Musculoskeletal and Skin Diseases, placing a new emphasis on dermatology's role in the public health. Money provided by this Committee has supported basic research that is finding causes and patterns of ichthyosis, and recommending effective treatments to reduce the disfiguring and debilitating effects of the disease. Most important, funding commitments from this Committee have provided the means to begin a pursuit of this disease to its very root, and to literally "change the face" of this generation and all those to come. For one hundred years, congressional support of the National Institutes of HEalth has carried out the humane, caring will of the American nation, with a success rate unmatched anywhere in the world, any time in history.

The Foundation For Ichthyosis and Related Skin Types supports the recommendations of the coalition of organizations concerned with the programs of the National Institute of Arthritis, Musculoskeletal and Skin Diseases, and asks for your approval of the $ 196,008,000 budget amount for the 1988 fiscal year. We are particularly concerned and enthusiastic that $ 2.55 million of that amount be allocated to the creation of six new core centers for skin disease research, and that the proposed clinical trials in ichthyosis and EB (epidermolysis bullosa) be implemented without further delay. We believe the ability to focus on dermatological needs and the flexibility to pursue promising research avenues through these core centers and research trials should be the highest priority in this year's budgeting.

The recent breakthroughs and success in dermatology are reflected in the high quality and promise of the grant requests submitted to NIH for funding next year. This Committee's support of the 1988 budget request can fund more of those exceptionally promising grants, and can see the great promise of this basic research realized, not only for the benefit of those suffering from ichthyosis, but for dozens of other diseases science is only now learning about through the newly expanded dermatology research.

Thank you again for the enduring confidence and support you share with us for the medical research of NIH. Thank you for allowing me this opportunity to speak to you today.

STATEMENT OF KAREN EISENBERG, NATIONAL FOUNDATION FOR ECTODERMAL DYSPLASIAS

Senator CHILES. Karen Eisenberg, now, with the National Foundation for Ectodermal Dysplasias.

Ms. EISENBERG. Hello, my name is Karen Eisenberg from Columbia, MD.

I am here today as a volunteer representing the National Foundation for Ectodermal Dysplasias, located in Mascoutah, IL.

But more importantly, I am here as the mother of a special little boy affected by one of the more than 130 ectodermal dysplasia syndromes.

Defined in the most basic of terms, ectodermal dysplasias are identified by at least two derivatives of the skin that do not function at all, or function poorly.

Difficulties encountered by patients affected by ED include sparse hair, absence of sweat glands, few if any teeth, insufficient tears or saliva, poorly functioning mucous membranes, sight and hearing deficits, missing limbs, and learning disabilities.

Medically, the most serious affects are related to the absence of sweat glands, which are responsible for high, frequent fevers.

Generally, long term treatments are required, which may include frequent denture changes, and extensive orthodontics.

The most common form of ED is hypohidrotic ectodermal dysplasia, otherwise known as Christ Siemens Touraine Syndrome.

I am particularly familiar with this type of ED, for it is this type that affects my son. Our family, like many others, had great difficulty getting a diagnosis for the troublesome fevers which were the source of many, many medical emergencies.

Fortunately for us, no additional long term damage resulted, but that has not been the case for many other families. A recently completed study done by Dr. Peter Harper at the University of Wales indicates that a 31-percent mortality rate is present among infants affected by ED.

Data collected by our foundation supports his findings. And a seriously high infant death rate also exists among our families here in the United States.

Every fever is accompanied by a great fear of what could occur. In addition, the potential for death, brain damage, can cause significant learning disabilities and paralysis.

Families must make adaptations to their lifestyles. Schools must have an air-conditioned environment. And even vocational selections are determined with ED in mind.

Our organization has been doing what we can to provide information on the disorders to those who request it. We have developed pamphlets and brochures which explain the various aspects of the diseases.

Meetings are held to assist families in dealing with the disorders. A limited amount of research money is being directed to nonbiological projects.

And we have even established a treatment fund to assist families with the financial burdens of ED. But there is a limit to what we can do, and that is why I am here today.

Our organization will never be able to support research at a funding level which will bring us to a true understanding of the disease and eventual cures.

Our organization adds our support for a budget of $196 million for the National Institute on Arthritis, Musculoskeletal and Skin Diseases. Funding at such a level will allow for the establishment of six skin disorder research centers vital to all individuals affected by skin disease.

These centers will help improve data collections on disorders like ED, which will lead to improvement in treatment.

Our sincerest hope is that the infant death rate for this disorder can be substantially reduced.

In addition, I would like to also add a word of support for the National Institute of Dental Research. NIDR has been the source of important studies on connective tissue.

Valuable research may shed light on questions surrounding ED. The projects which NIDR can support will benefit ED patients in the short term.

Studies on such treatment procedures as osseointegrated implants may be of great benefit to us.

We hope you will consider a funding level of $146 million for that Institute.

PREPARED STATEMENT

I appreciate having this opportunity to participate in these hearings and to express my views.

Senator CHILES. Thank you very much for coming.

[The statement follows:]

STATEMENT OF KAREN EISENBERG

Hello! My name is Karen Eisenberg from Columbia, Maryland. I am here today as a volunteer representing the National Foundation for Ectodermal Dysplasias which is located in Mascoutah, Illinois. But more importantly, I am here as the mother of a special boy affected by one of the more than 130 ectodermal dysplasia syndromes.

It is a real pleasure to be here, although I am somewhat new to the awesome challenge of presenting written or oral testimonies. With these new experiences I've quickly become educated to the respect and regard our congress has for the health and well being of the citizens of this country. Your past support of the National Institutes of Health is to be commended as is your foresight for supporting these agencies which continue to have such a positive influence on our health while utilizing and stretching our tax dollars wisely. All too often skin diseases are taken lightly. In fact when the term is mentioned most folks immediately have thoughts of acne or some type of rash which may be temporarily troublesome. But in reality there are skin disorders of such magnitude that disfigurement, emotional distress, and death are not uncommon results. The ectodermal dysplasias are a complex group of genetic skin disorders. Defined in the most basic of terms, ectodermal dysplasias are identified by at least two derivatives of the skin which do not function at all or function poorly. Consequently, all types of symptoms may be expressed in those affected by the disorders and to varying degrees. Difficulties encountered by patients affected by ED include: sparse hair, an absence of sweat glands, few, if any, teeth, insufficient tears or saliva, poorly functioning mucous membranes, sight and hearing deficits, missing limbs, and learning disabilities, Medically the most serious effects are related to the absence of sweat glands which is responsible for high, frequent fevers. Dentally, long term treatments are required which may include frequent denture changes and extensive orthodontics. The most common form of ED is hypohidrotic ectodermal dysplasia other wise known as Christ Siemems Touraine Syndrome. I am particularly familiar with this type of ED as it is the one that affects my son. I know first hand the fears and difficulties inherrent in dealing with a somewhat rare disorder. Our family, like many others, had great difficulty getting a diagnosis for the troublesome fevers which were the source of many medical emergencies. Fortunately, no additional long term damage resulted, but that has not been the case for other families. A recently completed study done by Dr. Peter Harper at the University of Wales indicates that a 31% mortality rate is present among infants affected by this type of ED. Data collected by the National Foundation for Ectodermal Dysplasias supports his findings as a seriously high infant death rate also exists among our families in the United States. ED is not an easy disease. It takes an enormous toll on the affected individual and their entire family. Emotional and ficancial stress are a frequent side affect and every fever is accompanied by great fear of what could occur. In addition to the potential for death, brain damage can cause significant learning disabilities and parallysis. Families must make adaptations to their life styles, schools must include an air conditioned environment, and even vocation selections are determined with ED in mind.

ED is nothing new. It has been documented in literature prior to the time of Charles Darwin. And although a lot has been written since, little has been done to improve our understanding of the disorders either from the stand point of basic science or treatment modalities. Perhaps as recently as a generation ago few individuals were identified as being affected by these disorders which may be due to a poor survival rate. However, our organization continues to hear from new families which leads us to believe that the numbers of individuals affected by ED is significant and worthy of our concern.

Our organization has been doing what we can to provide information on the disorders to those who request it. We have developed pamphlets and brochures which explain the various aspects of the diseases, meetings are held to assist families in dealing with the disorders, a limited amount of research money is being directed towards non-biological projects, and we've even established a treatment fund which assists families with the financial burdens of ED. But there is a limit to what we can do and that's why I am here today.

Ectodermal dysplasia is a somewhat rare and ususual birth defect and although we have begun to identify significant numbers of affected individuals we will never be able to support research at a funding level which will bring us to a true understanding of the disease and eventual cures. We are vitally interested in the operation and budgets of two institutes at the NIH. Along with others represented here today, our organization and the families I represent want to add our support for a budget of $196,000,000 for the National Institute of Arthritis, Musculoskeletal, and Skin Diseases. Our opinion has not been determined by a desire to go along with the crowd but by the real understanding that unless the numbers of research awards is increased there may never be room for projects directed to something so specialized as ED. In addition, we realize that funding at such a level will allow for the establishment of six skin disorder research centers. We view them as being vital to the needs of all individuals affected by skin disease. For it is through these centers that we would hope for improved data collection on disorders like ED which may well lead to a better understanding of these diseases and how individuals are affected which should in turn lead to treatment improvements. Naturally, our sincerest hope is that the infant death rate for this disorder could be substantially reduced as a result of such an eventuality.

In addition, I would like to add a word of support for the National Institute of Dental Research. NIDR has been the source of important studies on connective tissue. Potentially that valuable research may shed light on questions surrounding ED. But equally important are the kinds of projects which NIDR can support which will benefit ED patients on the short term. For example, studies on such treatment procedures as osseointegrated implants may be of great benefit to us. It is my sincere hope that you will consider a funding level of $146,000,000 for that institute.

My entry into the world of fiscal budgets, agencies like the National Institutes of Health, and congressional hearings is relatively recent. Even so, is didn't take long for me to be impressed by the quality of work, the dedication of employees, or the incredible medical advances being achieved at NIH. I realize that we are talking about a great deal of money but it is easy to defend expenditures which result in so many benefits for our common good and without cost overruns. I urge you to support NIAMS at a level of $196,000,000 and NIDR at $146,000,000 FY 1988.

I appreciate having this opportunity to participate in these hearings and to express my views. Thank you.

WHAT IS ECTODERMAL DYSPLASIA?

The ectodermal dysplasias are a complex group of genetic disorders which are identified by the absence or deficient function of a least two derivatives of the ectoderm. At least 120 differing ED syndromes have been identified.

HOW ARE PERSONS AFFECTED BY ED?

Those individuals who are affected by ectodermal dysplasia will have two or more of the following symptoms; sparse hair, eyelashes, and eyebrows; malformed fingernails; absent, mishapen, or poorly colored teeth; an absence of sweat pores; deficient tears and saliva; poorly functioning mucous membranes; frequent upper respiratory infections, hearing and/or sight deficit; missing fingers and/or toes; clefting of the lip and/or palate, and abnormalities in nipple development. 30% of those affected by hypohidrotic ectodermal dysplasia, the most common form of ED, are not expected to survive their infancy.

HOW DO THESE EFFECTS HAMPER THEIR LIVES?

Most people affected by ED have little or no ability to perspire. This complication is responsible for elevated temperatures which may cause significant brain damage or death. An air conditioned environment at home, at school, and in the work place is a necessity. Ongoing dental treatment is also almost always necessary. Dentures may be prepared for very young children while others may undergo more extensive therapies. Professional care may minimize the effects of sight or hearing deficits and cosmetic and/or surgical procedures may lessen facial deformities thus reducing physical disfigurement.

HOW MANY PEOPLE ARE AFFECTED BY ED?

We simply don't know. We do know, however, that far greater numbers of persons are affected by ED than was ever thought possible. The number may be as few as 1 in 50,000 or as many as 1 in 20,000.

WHAT KINDS OF DIFFICULTIES ARE ENCOUNTERED?

Perhaps the most common and serious problem is the lack of an early diagnosis. Following that problems related to care and treatment are nummerous. Families are routinely denied dental benefits even though the need for dental care is the direct result of a birth defect. As no tests exist which identify those who carry the gene for ED, women unknowingly pass on the gene to children who may be significantly affected. Adults affected by ED have great difficulty procurring either medical or life insurance.

WHAT COULD BE DONE TO SIGNIFICANTLY HELP THESE INDIVIDUALS?

Several important steps whould be taken to alleviate the suffering and significant infant mortality associated with ED. The development of a diagnostic protocol is urgently needed to insure the early diagnosis of the disorder. Testing which would identify those who carry the gene responsible for ED is an absolute necessity. Of greatest help to those affected would be treatment and research centers which would provide up to date information and therapies while at the same time gathering vital information which will aid in our understanding of these diseases and will encourage the develpment of more effective treatments resulting in better patient care.

STATEMENT OF ALLEN C. LOCKLIN, NATIONAL VITILIGO FOUNDATION

Senator CHILES. Now we will hear from Allen C. Locklin, of the National Vitiligo Foundation.

Mr. LOCKLIN. Thank you, Mr. Chairman. My name is Allen C. Locklin. My wife and I cofounded the National Vitiligo Foundation, Inc., some 18 months ago.

To the best of our knowledge it is the first national coordinated effort to try to advise people of the presence of vitiligo, which is characterized by white blotches on the skin due to loss of pigment.

It is a noncontagious but hereditary skin disorder that affects approximately 2¼ to 4½ million Americans, and it ranges strictly throughout all races in the same percentages.

It is much more apparent, certainly, on those with darker skin. I am a vitiligo patient, and have been for many years. And I stay out of the sun, basically, so it is not very apparent on me.

But I can assure you, if I got a good tan and went into a swimming pool, I could empty the pool, because people would not understand what it is.

It is a very unsightly, and emotionally and psychologically disturbing disorder. And the patients tend to, once they find that there is little—or troublesome ways to deal with it, they will generally become reclusive, withdraw from society, wear long sleeves, tall collars, makeup, stains, whatever they can do to hide the disorder.

Basically, everyone would like to be at least just one color. So it is very difficult to convey to people what emotional damage it has done.

And I certainly, in testimony last week before the House subcommittee, I was deeply moved by the problems other people had with their skin disorders. And certainly, what each person has is the most important thing to them. It is not what you do not have, necessarily.

But I am in great sympathy, and join in the chorus of pleas with this committee, to continue the funding at the level that has been requested of $196 million which includes the six core centers.

The importance of these core centers, as any kind of medical research will indicate, is that there are crossover benefits in research. Often, that which is being sought for is missed, and something new is found.

And we, as lay people in these different skin groups, are certainly aware of that. I think psorias, the PUVA someone mentioned a few minutes ago, was some of the treatment for vitiligo.

We have not come very far in vitiligo. We are still using the same drug discovered 4,000 years ago by the Egyptians. So we are still moving slowly.

But we do feel like there is great potential. Our foundation is in contact with 300 doctors in 23 countries, and we are getting tremendous feedback throughout the country from the people who are affected by this disease who have been neglected in many ways.

There are research areas at four of the major universities at least, including Howard University in this city. And we feel like the funding must continue.

And we as a foundation, my wife and I have personally given $70,000 to vitiligo research. And I say that not for self edification, but to show that we are serious about it. And we believe it needs to be attended to.

PREPARED STATEMENT

Thank you for your past help, and I pray for your continued support.

Senator CHILES. Thank you very much for your testimony.

[The statement follows:]

STATEMENT OF ALLEN C. LOCKLIN

Mr. Chairman and members of the committee, I am Allen C. Locklin, a geologist and president of a small oil company. I am also cofounder, with my wife, of the National Vitiligo Foundation, Inc., a nonprofit, charitable foundation formed to find, inform, and counsel all Vitiligo patients and their families; to increase public awareness and concern for the patient within the medical community and to encourage, promote, and fund increased scientific and clinical research on the cause, treatment, and ultimate cure of Vitiligo. It is further hoped that a central Vitiligo research center can be established along with local treatment facilities around the country.

Vitiligo, a noncontagious but hereditary disease is, as you can see from the color photographs, a disfiguring disorder resulting in pigment loss in the skin, showing as white patches. Except for itching and dryness of the skin and a greater chance for sunburn, there is no physical pain. But, as anyone who is the least bit vain can see, it presents a most unsightly appearance, leading to extreme psychological and emotional problems for the patients, including suicide. Marriages, jobs, and social activities are extremely effected by the occurrence of Vitiligo. A young soldier was recently discharged from the army because of his Vitiligo, as being a socially unaccepted problem. Children in particular are subject to taunts, isolation, and being ostracized because of their Vitiligo. Approximately 50 percent of all the patients have their Vitiligo before age 20.

The Vitiligo patient faces a greater risk of having hyperthyroidism and hypothyroidism, pernicious anemia, Addison's disease, Alopecia Areata and Uveitis. It also appears that some connection exists between Vitiligo and melanoma, the deadly form of skin cancer.

Many patients literally withdraw from society, others disguise their problem by wearing long sleeves, high collars, makup, and stains. Basically, each patient wants to be just one color. Vitiligo is not life threatening but it is: "Life Altering."

Vitiligo effects all races equally. It is more apparent in darker skin tones due to the sharp contrast between the white blotches and the pigmented areas. It is estimated that between 1 percent and 2 percent of the world's population has Vitiligo, meaning between 2¼ and 2½ million Americans have the disease. My personal belief is that the number is much higher. Many patients never see a doctor.

Our foundation is only 18 months old, but it is already very apparent that the Vitiligo patient has long suffered in silence and they are overjoyed to know someone is trying to help them. I have received letters and phone calls from around the world. We now have contact with over 300 doctors in 23 countries concerned about Vitiligo and anxious to help. These doctors are basically up to date on Vitiligo and its treatment and are eager to learn of new research. We hope to be a liaison tool and clearing house for them. Currently, we are exchanging information with other countries and Cuba has contacted us telling of a new drug with a high success rate.

Unfortunately, many patients have been told by their doctors to "Just learn to live with it." This is clearly wrong. There is hope. There are forms of treatment that offer some success for repigmenting. It is time consuming, tedious, and expensive.

For the most part, treatment has only slightly improved over thousands of years. We still rely mainly on the psoralen drugs which were first used by the Egyptians 4,000 years ago. You can see that we have not come very far. Research is going on, thanks to this committee but, it is very limited and much more is needed. Certainly any cuts in funding would be very detrimental to the programs.

Vitiligo falls under the newly designated National Institute of Arthritis and Musculoskeletal and Skin Diseases designated by Congress last year.

With the exception of some very small individual grants, only the money budgeted to the Consortium of Yale, Massachusetts, Cincinnati and Howard Universities is directed toward Vitiligo research. We support the $196 million level of funding requested for fiscal year 1988 from which that money is derived.

As a Vitiligo patient who has suffered the devastating effects of the disease, I have been trying to make a difference in Vitiligo research. Having been a political and philosophical conservative most of my life, I believe Government should play a limited role in many areas and particularly where public help can be marshalled. Therefore, my wife and I have contributed approximately $70,00 of our own money toward research and aid to the patient. I mention this involvement not for self-edification but to help you understand how important we think this disease is and that we've been willing to put up our money to find a solution to the problem. I am happy to report that some of that money has resulted in a significant advance. We have supported a research fellowship with Yale university on a 50–50 basis for 2 years, resulting in the discovery of a laboratory mouse for Vitiligo. Already at this early stage in the study of this new animal model there are findings that open a range of new approaches to the study and treatment of patients with Vitiligo and melanomas.

It is important to point out that the cross-over benefits of research can often lead to discoveries that aid people with diseases other than that being researched. This adds importance to the need for continued funding for research on the many diverse problems of the populace.

I would like to mention also that the budget provision of the National Institute of Arthritis and Musculoskeletal and Skin Diseases for $2,55 million to establish the creation of six new core centers for skin disease research is vital. These centers are important.

There are groups of people with diseases that must be helped by Government funding and certainly justifiable so. Vitiligo deserves help also but, I plan to continue to raise and contribute funds for research, thereby supplementing the effort on the part of the Government. But, in the meantime, please continue to do as you have in the past, support the funding level requested to keep the National Institutes of Health and the National Institute of Arthritis and Musculoskeletal and Skin Diseases healthy and viable. Thank you for allowing me time to testify and for your past and present help, I thank you also.

STATEMENT OF DR. ROBERT LAHITA, LUPUS FOUNDATION OF AMERICA, INC.

Senator CHILES. Dr. Robert Lahita with the Lupus Foundation of America.

Dr. LAHITA. Thank you, Mr. Chairman.

My name is Robert Lahita. I am a physician and associate professor at the Rockefeller University and chairman of the medical council of the Lupus Foundation of America.

We would parenthetically like to thank you and members of the subcommittee for your continued support of biomedical research up to this time.

And my purpose here today is to ensure your continue support of all of the immune diseases, lupus erythematosus in particular.

Lupus can be a very severe skin disease, but it is much more. It is a common disease of the immune system. It strikes both young and old, but prefers women in the child bearing years, particularly minority women, blacks and Hispanics.

Both the cause and the cure are unknown. The disease can affect 1 in 1,000 people in this country, and as many as 1 in 250 in Third World countries.

From the vantage point of the patient, the disease is frightening. It can present to the doctor as coma, kidney failure, devastating skin disease, or simply a persistent flu like illness that will not go away.

Mysteriously, many patients cannot go into the Sun. And a significant number are psychiatrically disturbed before an accurate diagnosis is made.

Perhaps no disease captures the spirit of modern medicine like lupus. Like other diseases of the immune system, the disease is a disease of our time.

Unlike those diseases that saps the immune system, this disease leads to hyperactivity of the immune system, a condition in which the patient's own cells and tissues become foreign to him or herself.

It is a fact that significant advances in research in lupus can directly impact on other diseases like multiple sclerosis and AIDS, and several of the diseases that you have heard about already this morning.

So this time it is crucial not only for patients with lupus erythematosus, but also for the most talented scientists and physicians who fear a decrease in NIH grant support, and attempts to use the biomedical budget to rectify other Federal deficits.

The general public will find that although biomedical research costs money, this cost is far less than the endless cost of human disease itself.

Our plea is to ensure your continued concern as the leaders of our government in meeting the need for fiscal support of research, not for diseases which immediately challenge the public safety, but all diseases, lupus included, which tax the public through a gradual and insidious process.

We are certain that you, the members of this Senate subcommittee, will continue your generous support of the NIH and the National Institute on Arthritis, Musculoskeletal and Skin Diseases and particularly research for lupus erythematosus.

Our patients, our researchers, and the general public are banking on you.

Thank you.

PREPARED STATEMENT

Senator CHILES. Thank you, and we appreciate your testimony.

[The statement follows:]

STATEMENT OF DR. ROBERT LAHITA

INTRODUCTION

The Lupus Foundation of America, Inc. (LFA), a national voluntary health agency representing people with lupus, their families, friends, and concerned others, welcomes the opportunity to submit a statement on FY 1988 appropriations for the National Institutes of Health. The LFA and its 100 affiliate chapters across the country recognize the strong commitment exerted by Congress on behalf of the work of the National Institutes of Health in its support for clinical and applied research related to immune system disorders, of which systemic lupus erythematosus is a notable example. This support has brought us closer to understanding and intervening in the immune system and has given hope and practical help to millions of people.

The context in which Congress has continued its active support of the NIH and biomedical research is recognized; during these years of high budget deficits and a legislative mandate to balance the federal budget, the weighing of national priorities is an arduous and awesome task. The Lupus Foundation of America agrees that among the highest priorities of this society is, and must be, the health and well-being of its people.

Lupus: An Immune System Disorder

Systemic Lupus Erythematosus (SLE), or lupus as it is commonly know, is a chronic inflammatory disease of the connective tissue. Instead of serving its normal protective function, the immune system forms antibodies that attack healthy tissues and organs, in effect, causing the body to become allergic to itself. There are two major forms of lupus. Discoid lupus affects only the skin, causing a rash and lesions, usually across the face and on the upper part of the body. Systemic lupus can attack any body organ or system, including the joints, kidneys, brain, heart, and lungs. This more severe form of the disease can be life-threatening, and is occasionally fatal.

It is estimated that as many as 1,000,000 Americans suffer from one or the other type of lupus and more than 16,000 people are diagnosed with systemic lupus each year. Lupus is a biased disease. Its victims are overwhelmingly women and its incidence is particularly pronounced among minority groups. The disease affects females, most often in their child-bearing years, almost nine times more frequently than males. About one in 700 women between the ages of 15 and 64 is afflicted. Among Hispanic women, one in 410 is afflicted, and among Black women, one in 245.

Lupus is difficult to diagnose. The symptoms, including extreme fatigue, diminished appetite and weight loss, chronic or recurrent low grade fever, hair loss, and pain in the joints and/or inflammation, mimic those of other illnesses and are diffuse in nature. It is not unusual for a diagnosis of lupus to take from five to ten years from the initial onset of symptoms. Perhaps the most discouraging fact about lupus is that, as yet, there is no known cause or cure. Victims of this chronic and debilitating disease look for hope to the biomedical research currently under way and projected for the future.

The Status of Lupus Research

Medical scientists are now examining the interactions of the immune, endocrine, and nervous systems. Their investigations may enable us to understand such phenomena as the patient's attitude in a number of diseases. Direct nerve connections have been discovered between the brain and the thymus and spleen. Most of the antibody against foreign antigens in the blood is produced in the spleen. In addition, studies on recently bereaved individuals indicate that the stress of bereavement affects immune system responsiveness. In addition to studies in humans, excellent experimental models of lupus have been developed and intensively investigated in certain inbred strains of mice. These important animal models are immunologically very similar to humans with lupus, and much of what is learned from these studies can be applied to humans. Investigators have demonstrated that psychological "conditioning" can induce either suppression or increase in immune responses in experimental animals, depending on the circumstances.

Important advances have also been made, through biomedical research, to identify and investigate new therapeutic approaches to the treatment of lupus. These include pulse therapy, plasmapheresis, intravenous cyclophosphamide, total lymphoid irradiation, use of anti-DNA antibodies, induction of tolerance to self-antigens, and immunoreplacement therapy. Research on lupus has directly led to the formulation and critical testing of new concepts about its nature.

Sponsors of Lupus Research

Lupus research is supported by several Institutes of the NIH, foremost the new National Institute of Arthritis, Musculoskeletal and Skin Diseases (NIAMSD), and also the National Institute of Allergy and Infectious Diseases (NIAID). Private industry has also loaned its support for such research through company-owned facilities. Nonprofit organizations, such as the Lupus Foundation of America, maintain an active research grants program. Each year, the LFA sponsors between 10 and 20 research projects on the causes of, treatment and cure for lupus, as well as a program of summer fellowships to encourage young biomedical researchers to focus their studies on lupus and related immune system disorders. These private and voluntary agencies can and do provide the initiative and support to formulate and test theories and encourage the most promising research that may be proposed for extramural support by NIH and related federal agencies concerned with health promotion.

An Agenda for 1988

Diseases of the immune system are now "big news," due to the widespread publicity and public concerns about AIDS. Although many know about AIDS, a sizeable proportion of our citizens are not aware that millions of Americans suffers from other immune system disorders, at a cost of billions of dollars annually in terms of lost work and productivity, health care, disability, other insurances, etc. Of increasing concern is whether funding to support AIDS research may take from, rather than augment, basic and applied studies related to the numerous other immunologic disorders that affect millions of Americans. Sponsored research must emphasize the application of findings not only to one, but to all related diseases. As our health care costs continue to rise, the issues of disease prevention and expanded funding of basic and clinical research also become even more important. Cost factors aside, humanitarian values would suggest that high priority be given to prevention. The technology of prevention, if not cure, is within our reach.

Available NIH data show that approximately $22,265,000 will be spent on lupus research during this current 1987 fiscal year. Projected expenditures for FY 1988 show a constant level of support, but in real dollars, actually represents a funding decrease. At the same time that we stand on the threshold of new breakthroughs in immunologic disease, we are concurrently closing the door to the future by discouraging biomedical career development opportunities. The consequences will be a severe deficit of talent for biomedical research of a profound and long-term nature.

In summary, the Lupus Foundation of America, Inc. urges Congress, in considering FY 1988 allocations, to:

- Increase FY 1988 fiscal allocations for the National Institutes of Health by at least 5 percent over FY 1987 levels, to ensure a minimum continued level of support consistent with rising cost factors.
- Increase the specific allocations for research into the causes of, treatment and cure for lupus, commensurate with its seriousness and pervasiveness within the United States.

- Ensure that the funds allocated for AIDS research are not "borrowed" or deducted from other biomedical research areas, and that reports of publicly funded AIDS research projects be required to show their applicability to other immune system disorders.
- Expand researcher programs for young medical scientists through special grant awards and/or fellowships to encourage their entrance into and longevity within this field.

The LFA pledges to continue its role in encouraging and directly sponsoring lupus research, particularly pilot projects which may form the prototype of larger studies eligible for NIH support. We also commit ourselves to a partnership with NIH to promote, disseminate and put to practical and life-saving use the results of these biomedical studies.

Senator CHILES. Now we will hear from Victor Burguess of Orlando and Arlene Pessar with the Dystrophic Epidermolysis Bullosa Research Association.

First I think Senator Hatfield wanted to make some statement.

Senator HATFIELD. Well, Mr. Chairman, I am so grateful to you for your thoughtfulness in adjusting your schedule here to meet my schedule, and to give me an opportunity not only to welcome Will Wachtel, who has already testified from Portland, OR, but especially at this moment to welcome testimony now on EB.

Mr. Chairman, just a week ago last night a young gentleman by the name of Cal Larson passed away who, along with Arlene and others, had covered these halls, office by office, to bring our attention to this terrible affliction that he experienced and others like him. It was his efforts which largely launched the NIH into a specific research program.

And his parents are here this morning to show their continued support for this research, and we are so grateful for the wonderful leadership young Cal gave, and others who have now brought this into focus to help provide the base for support.

And we are most grateful to Arlene Pessar, who has helped launch the parent association, and her son Eric, who is also a victim of this malady.

And so I just want to thank you, Mr. Chairman, for the special support you have given along with others on this committee to help find the solution and the answers to this.

Senator CHILES. Thank you, Senator Hatfield.

STATEMENTS OF:

VICTOR BURGUESS, ORLANDO, FL

ARLENE PESSAR, R.N., EXECUTIVE DIRECTOR, DYSTROPHIC EPIDERMOLYSIS BULLOSA RESEARCH ASSOCIATION OF AMERICA, INC.

Ms. PESSAR. Thank you, Mr. Chairman, Senator Hatfield.

Good morning. I am Arlene Pessar, and am the founder and director of the Dystrophic Epidermolysis Bullosa Research Association. I will be sharing my time this morning with Mr. Victor Burguess from Orlando, FL, because I believe he has an important story to tell. And that is my son, Eric Lopez.

This is the sixth year we are appearing before this committee. And I must say, as Senator Hatfield alluded to, this year is my most difficult.

For the past 5 years I have been accompanied to these hearings by Cal Larson, who you know. And Cal is not with us today because after 25 years of suffering, he passed away last week as a result of complication of epidermolysis bullosa.

But while EB may be having a personal devastating affect on our own lives, I would like you to know that there are some exciting and wonderful things happening in EB research, for which I am thankful; thankful, and hopeful and grateful to this committee and the members who are part of it, for providing the funds to expand the research programs in epidermolysis bullosa.

I would just like to take a minute now to update you on some of this important progress, and express my views on the importance of establishing research centers in dermatology.

Since 1982, when this committee first recognized epidermolysis bullosa as a life threatening genetic disease, much progress has been made toward finding the causes.

We believe the next step to further capitalize on all the success is the establishment of research centers. I understand that at present no such centers exist in dermatology today.

Therefore, we would like to endorse the recommendations made by Dr. Grupenhoff and the other members of our skin coalition and urge you to provide $2.5 million to create six core centers to study dermatological research.

As a very personal request, I ask that you authorize that one such center be named in memory of our friend, Cal Larson.

Mr. Chairman, in my heart, I believe that one day there will be a cure for many of these skin diseases. As a parent of a child who suffers from an incurable and debilitating disease, I strongly believe I cannot ask others to help my son if I do not do everything in my power to help him myself.

But I also know that our efforts alone cannot conquer this disease. And that is why we keep coming back here year after year.

There has been much suffering, and too many deaths. The future of our children depends on your leadership and continued support.

Your concern has made a difference, and we urge you to continue to make a difference.

Thank you.

Senator CHILES. Thank you. Mr. Burguess, nice to have you with us.

STATEMENT OF VICTOR BURGUESS

Mr. BURGUESS. Senator Chiles, and members of the subcommittee, my name is Victor Burguess. I live in Longwood, FL, and have come here today to share my family's experience with epidermolysis bullosa in the hopes that it will help others in the future.

On January 15, 1987, our daughter, Estelle Victoria, was born with epidermolysis bullosa.

Estie was 3 weeks premature, and lacking skin on her neck and on her right leg from the knee down. This abnormality devastated my wife and I, as we already have a 2-year-old child with no abnormalities, and had no reason to suspect that we both carry a gene for EB.

Estie was also diagnosed as having a rare complication of EB called Pyloric atresia. She underwent surgery at 5 days, and survived the delicate procedure.

Unfortutely, because of the preparation and handling for surgery, 40 percent of her body was now blistered. Estie was unofficially diagnosed with junctional EB 24 hours after her birth.

Since then, our lives have been severely impacted by the disease. The usual calls to grandparents and family members were quite difficult, as we had to inform them of this condition without any real information.

Looking back, our discussions on surgery, birth defects, finances, now seem petty compared to the reality of Estie's condition.

We underwent a search for information by calling every known establishment in the world that might help us find answers. A commonality in our search was DEBRA.

Arlene Pessar, its director, was instrumental in putting us in touch with the leading professionals experienced with EB. Dr. Maxine Tabas, a colleague of Dr. Eugene Bauer from St. Louis, came to Florida and examined Estie.

For the first time, someone other than the distraught and emotionally involved parents directed the hospital staff on the care of our child.

Dr. Tabas also confirmed the diagnosis. Information and demonstrations on bandage changing, feeding and handling our fragile infant allowed my wife and I to undertake caring for our daughter.

We quickly became the resident professionals on EB, and we passed out numerous articles and materials to the hospital staff. We discussed moving Estie to a more appropriate facility, but soon learned that even if we were to travel the globe, there was no place that could offer our child the help that we needed.

We were both relieved and distressed by this. We would not have to disrupt our already stressed family by moving to a different location.

At the same time, we were devastated because we could not help a dear member of our family.

On Good Friday, Estie was released from the hospital, not because she was better, but because we could provide better care for her at home.

A great deal of equipment and our own nursing staff was in place so that we could give her the consistent care and love that we needed.

Holding her, showing her the Sun and her older sister was the best we could offer.

We continue to fear the risk of having other children, because of the astronomical odds of producing another child with EB.

And what about our daughter, and the other members of our families? Are they at risk of carrying the gene? At present, there is no way to detect the carrier state, and there is little, if any research being done on the genetics of EB.

In closing, let me state that this committee is to be commended for its successful efforts in advanced research in EB. However, I hope you note that my presence here today simply means that not enough has been done.

My daughter was treated no differently than Edward Wanat, whose father spoke to you 3 years ago shortly after his newborn son died of this disease.

Will the person who speaks next year tell the same sad story?

PREPARED STATEMENTS

Senator CHILES. Thank you for coming up here and sharing that with us. We appreciate that very much. And thank you both.

[The statements follow:]

STATEMENT OF ARLENE PRESSAR

SUMMARY OF RECOMMENDATIONS

1. That FY 1988 appropriations for the National Institutes of Health (NIH) be approved at a funding level of $7,690 billion as proposed by the Ad Hoc Group for Medical Research Funding.

2. That FY 1988 appropriations for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMD) be approved at a funding level of $196,008,000.

3. That $2.55 million be provided to establish six dermatology centers. That one such center be named in honor of Cal Larson, a courageous and unselfish young man who helped bring the plight of epidermolysis bullosa to the attention of the public and the Congress.

Mr. Chairman, members of the subcommittee:

Good afternoon.

I am Arlene Pessar, the founder and director of the Dystrophic Epidermolysis Bullosa Research Association of America (D.E.B.R.A.). I am also a member of the new Advisory Council of the National Institute of Arthritis and Musculoskeletal and Skin Diseases, and serve on the Board of Directors of the National Organization for Rare Disorders (NORD) and the Alliance of Genetic Support Groups. Most importantly, I am the parent of a 16-year old son with epidermolysis bullosa.

Epidermolysis Bullosa (EB) is a group of inherited disorders in which the skin and other epithelial surfaces are so fragile that the slightest touch may cause painful blistering and eroding of the skin. EB, a life-long disease often present at birth, causes severe physical, emotional and financial hardships for the affected persons and their families. It is estimated that 50,000 Americans, mostly children and young adults, suffer from EB. The fatality rate is high.

D.E.B.R.A. of America, founded in 1980, is a young organization working to improve the quality of life for patients and families who suffer from life-threatening and catastrophic skin diseases, such as epidermolysis bullosa.

This is the sixth time I am testifying before this Committee, and I must admit this year is my most difficult.

For the past five years I have been accompanied to these hearings by Cal Larson -- who many of you know. Cal is not with us today because he is gravely ill; after 25 years of suffering, Cal is losing his own personal battle against EB.

Testifying with me this afternoon is Mr. Victor Burguess from Longwood, Florida. His story is an important one to share. Like so many other young parents whose children are born with EB -- in a very short time -- Victor and his wife, Kathy's notion of the "all American dream" has become one of despair, helplessness and financial devastation.

And this summer, instead of searching for the "right" college like most other high school juniors, my son, Eric, will be undergoing complicated surgery to relieve the contractures and scar tissue that prevent him from walking without constant pain.

Yet... despite the grim picture I have just painted, I am still hopeful and thankful. Thankful and grateful to this Committee, and the members of their staff, who have been compassionate, understanding and generous in their support of the new National Institute of Arthritis and Musculoskeletal and Skin Diseases.

I am especially grateful for your extraordinary leadership and support in providing funds to expand the research programs in EB.

I would like to use my time today to update you on some of the progress that has been made in EB. By sharing these exciting advances, I wish to emphasize the need for keeping NIH funding a top priority so the important groundwork that has been laid toward solving the EB puzzle is not lost.

In 1982 this Committee recognized that "epidermolysis bullosa is a life-threatening genetic disease" and directed funds be used to expand the research programs on EB. As a result of that language, and subsequent language in future bill reports, impressive strides have been made in the basic science of EB.

Recent techniques of immunohistochemistry have been useful in improving the identification of cases, and shortening the time to make an accurate diagnosis. Fluorescent-labelled antibodies have been developed which can define normal components of the basement membrane zone of the skin, and allow direct visualization of the exact site where the blistering is originating.

We are also encouraged and pleased to report that the Institute is now supporting a National Registry of EB Patients. In addition to collecting information on the genetics of EB, determine the incidence and prevalence of the disease, the registry will act as an interface between researchers interested in the disease, and patients willing to participate in various research projects. We are optimistic that this research will lead to improved therapies, a test to determine who is carrying the gene for EB, and ultimately, prevention of both the disease and its terrible complications.

The next steps to expand the research efforts in EB and related diseases are clearer than ever before. I believe the combined goals of research and care are finally within our reach, and could be realized by Congressional authorization to establish several dermatology centers. Such centers are an effective and productive means of focusing research efforts in high priority areas.

Therefore, we strongly support the recommendations of our colleagues and endorse a level of funding of, at least, $196,008,000 for the National Institute of Arthritis and

Musculoskeletal and Skin Diseases for FY 1988. This recommendation would allow 40% of the research grants approved by the study sections to be funded.

The proposed $196,008,000 includes funds to develop six dermatology centers. We strongly endorse the establishment of these six centers and urge you to provide both the $2.55 million for the centers and report language to ensure that these centers of excellence are created.

In closing, I have one more request and this is a very personal one. I ask that when these dermatology centers are developed, one center be named in honor of Cal Larson, a courageous and unselfish man who helped bring the plight of EB to the attention of the public and the Congress.

Mr. Chairman, as parents of children with EB, we strongly believe we cannot ask others to help our children if we do not do everything possible to help them ourselves. But we also know that our efforts alone cannot conquer this disease. That is why we keep coming back here year after year.

The future of our children depends on your leadership and support. Your support has made a difference. We urge you to continue to make a difference.

Thank you for giving us the unique opportunity to participate in a very important process. I hope to bring you encouraging news next year. And who knows, maybe one day soon, we'll just come back to say hello and thank you.

STATEMENT OF VICTOR BURGUESS

Mr. Chairman and Members of the Subcommittee. My name is Victor Burguess. I live in Longwood, Florida. I have been invited here today and asked to share my family's experience with Epidermolysis Bullosa in the hopes that it will help others in the future.

On January 15, 1987 our daughter, Estelle Victoria, was born with Epidermolysis Bullosa (EB). Estelle was three weeks premature and lacking skin on her neck and her right leg from the knee down.

This abnormality devastated my wife and I as we already have a two-year old child with no abnormalities, and had no reason to suspect that we each carried a gene for EB.

Estee was also diagnosed as having a rare complication often associated with her form of EB called pyloric atresia. She underwent surgery at five days and survived the delicate procedure. Unfortunately because of the preparation and handling for surgery, 40% of her body was now blistered.

Estee was unofficially diagnosed with Junctional EB 24 hours after her birth. Since then our lives have been severely impacted by this disease. The usual calls to grandparents and family members were quite difficult as we had to inform them of this condition without any real information. Looking back, our discussions on surgery, birth defects, finances now seem petty in comparison to the reality of Estee's condition.

We underwent a search for information by calling every known establishment in the world that we thought might help us find answers. A commonality in our search was D.E.B.R.A. Arlene Pessar, its director, was instrumental in putting us in touch with the leading professionals experienced with EB.

Dr Maxine Tabas, a colleague of Dr Eugene Bauer from St Louis, came to Florida and examined Estee. For the first time someone other than the "distraught and emotionally involved parents" directed the hospital staff on the care of our child. Dr Tabas also confirmed the diagnosis. Information and demonstrations on bandage changing, feeding, and handling our fragile infant allowed my wife and I to undertake caring for our daughter. We quickly became the resident professionals on EB, and we passed out numerous articles and material to the hospital staff. We begged them to contact others with more experience and expertise. We discussed moving Estee to a more appropriate facility, but soon learned that even if we were to travel the globe, there was no place that could offer our child the help she needed.

We were both relieved and distressed by this. We would not have to disrupt our already stressed family by moving to a different location. At the same time we were devastated because we could not help a dear member of our family.

Last Friday, Estee was released from the hospital. Not because she is better, but because we can provide better care for her at home. A great deal of equipment and our own nursing staff is in place so that we can give her the consistant care and love she needs. Holding her, showing her the sun, and looking at her older sister is the best we can offer.

Her stomach is non-functional and she can only be fed through intravenous; although this solution barely provides the nutrients she needs to sustain her. At three months her weight remains 4 lbs. 5 oz. She continues to survive although we do not understand how.

She does not look at us with the eyes of a child nor does she respond to the gentle caress and murmurs of her mother and sister. At this time no one is sure what her future holds. We also fear the risk of having other children because of the astronomical odds of producing another offspring with EB. And what about our daughter and the other members of our families? Are they at risk of carrying the gene? At present there is no way to detect the carrier state, and there is little, if any, research being done on the genetics of EB.

In closing let me state that this committee is to be commended for its successful efforts to advance research in EB. However, I hope you note that my presence here today simply means that not enough has been done. My daughter was treated no differently than Edward Wanat, whose father spoke to you three years ago, shortly after his newborn son died from this disease. Will the person who speaks next year tell this same sad story?

If we cannot - and we cannot - present a cure, then let's create centers to centralize, categorize and distribute existing information about EB, so hospitals all over the country do not "reinvent" treatment approaches whenever they encounter an EB baby. Focused funding to support an effective educational program and research to determine the carrier state, establish an accurate prenatal diagnosis, and seek treatment and a cure for this disease is desperately needed. EB deserves government support at all levels.

Your attention to these matters is appreciated.

Thank you.

STATEMENT OF MARTHA WOODHOUSE, NATIONAL CONGENITAL PORT WINE STAIN FOUNDATION

Senator CHILES. Martha Woodhouse now, with the National Congenital Port Wine Stain Foundation.

Senator BURDICK [presiding]. You may proceed.

Ms. WOODHOUSE. Thank you, Mr. Chairman, and members of the subcommittee:

I am Martha Woodhouse, a wife, mother of three children, and a teacher in Rockland County, NY.

I have worked in the field of human services and special education since 1969. Upon graduation from Columbia University in 1985, we planned the birth of our third child Sarah.

We were very careful to follow all the known procedures to ensure a healthy child's birth, including prenatal diagnosis, a test called chorionic villus sampling. The test results were good, but the procedure itself went in a little too far and damaged the developing umbilical cord.

Sarah was delivered by means of an emergency Ceasarian section with an umbilical cord only 3 inches long. At first, when she was born, we learned about the port-wine stain. We learned the meaning of a birthmark.

Sarah's port-wine stain covers 40 percent of her body. At first we thought a birthmark was only a cosmetic problem. We were told that it was caused by a malformation of capillaries left over from early prenatal development.

The research has indicated that the port-wine stain is an abnormal vessel retention. Unfortunately, shortly after we learned and dealt with Sarah's birthmark, we learned that because of the configuration of her port-wine stain, she was also at risk for having a dreaded disease called Sturge-Weber syndrome.

Now, the Sturge-Weber syndrome means that there is actually—the port-wine stain on one of the internal organs. For example, if her port-wine stain had been on the surface of her eye, she could have been born with glaucoma.

If the port-wine stain was on the surface of the brain, neurological complications could occur, and she could have a seizure disorder that would be almost impossible to control with normal medications.

Sarah will have to be checked by a doctor, by a neurologist, by an ophthalmologist, regularly, for the rest of her life.

Her leg, which is also covered by the port-wine stain, is expected to grow at a different rate than her normal leg.

I am here today with my daughter and family on behalf of the National Congenital Port-Wine Stain Foundation, which is a new foundation which was developed less than 1 year ago.

And we are here to ask you to please support the request from the National Institute on Arthritis, Musculoskeletal and Skin Diseases and support, please at $196 million.

Now, $2.55 million of that will be for the creation of six dermatology core research centers. The research centers are greatly needed to establish a base where major strides can be made.

And a very important reason for the core research center is to have carefully controlled research. Many types of research can go on, but unless the research is carefully controlled, it is hard to depend on the outcomes.

Anyone who thinks that this and other skin diseases is merely cosmetic has not taken time to consider the psychological, interpersonal and vocational consequences of this type of affliction.

The information presented today is based on the research currently available. Unfortunately, much more is unknown than is known at this time about the port-wine stain, about the Sturge-Weber.

One thing that we do know is that at adolesence Sarah's port-wine stain, which is soft and pink right now, will probably turn more like these pictures of a much thicker, coarser skin that is not as pleasing.

And it makes cosmetic application much more difficult, and it makes acceptance by others much more difficult.

Your support for this valuable research brings us closer to the day when children and families will not have to suffer unnecessarily as we and other families that you see here today have suffered.

Each year, 0.3 percent of our children are born with some type of a birthmark. That translates to approximately 7 million Americans who have some type of a birthmark. Some are insignificant and some are very serious.

And only through careful research can we help those that have the more serious problems.

And I brought with me today, also, the names of about 150 children across the United States with Sturge-Weber, and I am speaking for them also.

Thank you.

PREPARED STATEMENT

Senator BURDICK. Thank you very much for your testimony. It will be helpful, I am sure.

[The statement follows:]

STATEMENT OF MARTHA WOODHOUSE

I am Martha Woodhouse, a wife, a mother of three children and a teacher in Rockland County, New York. I have worked in the field of human services and special education since 1969. I graduated from Columbia University on May 15,1985. Upon graduation, my husband and I began planning for our third child. We were very careful to follow all the "known" right things to do to ensure a healthy child's birth. We had an early pre-natal diagnosis test done called Chorionic Villus Sampling (CVS). The test results were good, but the procedure itself which is performed at the site of the developing umbilical cord, hit the baby in utero and arrested the development of the umbilical cord.

Sarah was delivered by means of an emergency Caeserean section because a short umbilical cord of only 3 inches would not allow the natural birth process to continue.
At Sarah's birth, we experienced her near death.
Then, we learned the meaning of a "birthmark". Sarah was born with a Port-Wine Stain that covers 40% of her body.

We thought that a "birthmark" was a cosmetic problem on the surface of the skin. We learned that a Port-Wine Stain was actually caused by a malformation of capillaries left over from the first month of primitive prenatal development. Research has indicated several possible causes of this abnormal vessel retention including: an intra-uterine traumatic event, infection or an environmental exposure.

Unfortunately, we learned that the pattern and distribution of Sarah's Port-Wine Stain was an indicator that she
was also at risk for developing complications of a syndrome called Sturge-Weber.

The Sturge-Weber Syndrome is truly a nightmare...
Sarah would have to be checked regularly for Glaucoma. If there were signs of malformed capillaries on the back of her eye, pressure could build and cause blindness.

Sarah would have to be monitored regularly by a Neurologist. If there were malformed capillaries on the surface of the brain, these lesions could cause a seizure disorder which is very difficult to control and often results in mental retardation. Intracranial calcifications might be present. Hemiparesis might also be detected as a weakness on one side, and could impair motor development of her limbs.

In addition, Sarah's leg would have to be measured carefully in length and width as she grew. A vascular malformation on an entire limb could cause the growth of her leg to be abnormal.

At birth, Sarah's future looked grim. We were devastated with fear of her emotional adjustment, possible blindness in both eyes, her mental functioning being impaired and the possibility of her being physically disabled.

I am here today with my daughter, Sarah, on behalf of the National Congenital Port-Wine Stain Foundation to request funding for the National Institute of Arthritis, Musculoskeletal and Skin Diseases. (NIAMS) We are asking for your support at the level of $196,000,000.

Please note that $2.55 million of the requested $196,000,000 will be used for the creation of six dermatology research centers. These dermatology centers are greatly needed to establish a base where major strides can be made in understanding the causes of these skin diseases and in developing new and successful treatments.

Anyone who thinks that this and other skin diseases are merely "cosmetic" has not taken the time to consider the psychological, inter-personal and vocational consequences of this type of affliction and should not underestimate its impact on us as a nation.

The information I have presented today is based on the research currently available. Unfortunately, much more remains unkown than is known at the present time. And, most importantly, what is the prognosis for our daughter and the other children born with Port-Wine Stains and the Sturge-Weber Syndrome?

Only continued and increased medical and scientific research can shed light on these and other crucial questions. We must do all we can to insure that research continues to protect our nation's children from future mistakes.

Your support for this valuable research may bring us closer to the day when children and their families will not suffer unnecessarily as we have. Each year 0.3% of our nation's newborn children have a Port-Wine Stain (nevus flammeus). This would translate to about 7 million afflicted Americans.

Thank you for your continued support and consideration of our request.

STATEMENT OF ALBERT E. GUNN, M.D., UNIVERSITY OF TEXAS, HEALTH SCIENCE CENTER AT HOUSTON

Senator BURDICK. The next witness will be Albert Gunn, M.D., University of Texas Health Center at Houston.

Dr. GUNN. Thank you for the opportunity to speak, Mr. Chairman.

My name is Albert Gunn, and I am the chairman of the Board of Regents of the National Library of Medicine; associate professor of Medicine and associate dean at the University of Texas Medical School at Houston.

The National Library of Medicine last year celebrated its 150th anniversary. It started out as a row of books on some Civil War surgeon's shelf, and it grew into the greatest medical and biomedical center of information in the world.

Today it is unparalleled in any country or in any institution for the amount of resources that are available to the medical researcher and for medical progress.

John Shaw Billings, a Civil War surgeon who was instrumental in bringing the library to its eminence, personally selected the journals that went into its esteemed index medica, or index of medical journals, which research is widely used in the course of their researches.

Today that is not possible for one man to encompass such a wide role of learning. Most doctors like myself are incompetent. It is difficult to say that.

We cannot possibly know all the information that is available to the practicing physician. In fact, it cannot even be contained in books at the present time.

There is so much information that only computers, at times, can store it, particularly in the field of genetics.

I do not think anyone could fail to be touched by the testimony that I heard from the previous witnesses as to the impact of disease on the individuals and on the families, and for that matter, on society.

And you cannot argue with the fact that there has got to be more research in many facets. But the basis of that research is helped by the National Library of Medicine.

Because it now is not merely a collection of books of antiquarian interest, but it is a leader in the field of medical informatics, that is, the application of the computer to medical learning, to medical research, to the storage of medical facts.

And this is an expanding field. The National Library of Medicine no longer is a chronicler of medical research, but it is a developer of medical research because it participates in the progress by its capacities in medical informatics.

Mr. Chairman, I would like to particularly draw your attention to House Resolution 393, which is a bill to establish a center of biotechnology information within the Department of Health and Human Services as a component of the National Library of Medicine.

And this is the wave of the future. Because somewhere in the Government, or some institution—and I don't think any private institution could undertake such a task—there has to be a method of storing all the information that the scientists, who are attacking these diseases that you have heard testimony about today, and which you know from other collateral subjects, can use.

The scientists must be aware of what has gone before him, so he does not duplicate research, and he must be able to see what advances have been made so he can base his research on this.

PREPARED STATEMENT

I hope that the National Library of Medicine will receive your favorable attention, as it has in the last 150 years.

Thank you for the opportunity to testify.

Senator BURDICK. Thank you.

[The statement follows:]

STATEMENT OF ALBERT E. GUNN

Mr. Chairman. I am Dr. Albert E. Gunn, Associate Professor of Medicine, and Associate Dean for Admissions, University of Texas Medical School. As a physician and medical educator, and as Chairman of the National Library of Medicine's Board of Regents, I welcome this opportunity to speak in behalf of the important programs conducted by the Library.

The National Library of Medicine has long stood as a respected force behind our country's extraordinary advances in biomedical research. The scientific community is very much aware that the systematic organization and dissemination of biomedical information and--equally important--support of research programs in information handling techniques, are essential to progress in medicine. Without them, wasteful duplication of research and ultimately, a loss of important new medical concepts in patient care, result. Yet, the proposed budget for the National Library of Medicine, the prime source of federal support for information technology research, and the key link in the dissemination of biomedical research results would seriously underfund these activities. It would jeopardize the optimum use of biomedical information. In view of the billions of dollars this Nation invests in biomedical research, I believe such lack of support for programs designed to manage research results, would be bad management.

Effectively and efficiently disseminating the results of the research process is becoming increasingly more complex as we move toward the 21st century. The National Library of Medicine is without question the intellectual center of the world's biomedical information network. However, to remain so, the organization must respond to dynamic changes in biomedicine and technology. To ensure these challenges are met, an innovative and comprehensive long-range planning project was undertaken by the NLM Board of Regents. The project recognized that before future activities and resource requirements could be established, the NLM's mission and user requirements needed to be carefully examined. Panels of experts representing the scientific user population were convened, each with a charge to investigate a domain within the NLM's mission. The resulting recommendations gleaned from the concerted efforts of more than one hundred outstanding individuals have been combined in a comprehensive and visionary report that represents a map for the future, and a set of opportunities that await NLM action and program development.

I would like to call your attention to one opportunity with enormous return in the provision of improved health care in this country. The Board of Regents has recommended that NLM assume a leadership role in the crucial area of molecular biology and biotechnology information handling. Much has been written lately about the extraordinary promise of biotechnology research into the understanding and control of life processes. Scientists agree that the keys to many of the world's debilitating diseases lie in the complex relationship between disease and genetic function and that by unraveling genetic complexities, they may find cures. They agree too that the unraveling requires the manipulation and exchange of unimaginable amounts of data and information.

The panel experts reported that "..because of new automated laboratory methods, genetic and biochemical data are accumulating faster than they can be assimilated into the scientific literature. The problems of scientific research in biotechnology are increasingly problems of information science. By applying its expertise in computer technologies to the work of understanding the structure and function of living cells on a molecular level, NLM can assist and hasten the Nation's entry into a remarkable new age of knowledge in the biological sciences."

This "window of opportunity" has been recognized also by the Honorable Claude Pepper who has introduced legislation that would establish a center for biotechnology information as a component within the NLM. The center would store biotechnology information, build links among existing data banks, and create new computerized systems that would allow scientists around the United States to share the molecular genetic information coming from the nation's laboratories. NLM is uniquely qualified to be the site of such an important center.

The Long-range plan clearly delineates other priorities for the National Library of Medicine as well. It reaffirms NLM's fundamental mission to provide high quality library and information services to the biomedical information community. This, by the way, will be no easy task if the NLM is subject to the proposed budget before you today, a budget that is 2 million dollars less than required simply to provide basic library and information services. NLM programs also at risk include medical informatics research and training, a program that the NLM has supported for over ten years involving the integration of computer and information sciences; the development of prototype integrated academic information management systems that may ultimately form the foundation for an interactive national biomedical information system; the development of a unified medical language recognized as an important step in enhancing medical communications; and other library assistance awards that would assist in bringing to our nation's medical and health-related libraries the benefits of the latest information science technology.

In conclusion, Mr. Chairman, I am deeply concerned about a budget that would hamper current Library activities and would undermine remarkable new initiatives. I respectfully urge this committee to prevent a "status quo" situation in an organization that by its very reason for being--to serve the nation as a dynamic biomedical information resource--cannot afford to stagnate.

Specifically, it is estimated that a $14.7 million increase over the FY88 proposal is necessary to cover NLM's basic library services, and to ensure its current important research initiatives. An additional $10 million would be required to fund the Center for Biotechnology Information. I urge your support in this important endeavor, and an overall budget of $89 million for the National Library of Medicine.

Senator Burdick. Doctor, being an old book man myself, I was wondering, there are centers, various centers, where this material is kept now. There are several centers, are there not, around the country?

Dr. Gunn. That is right.

Senator Burdick. Different cities have libraries?

Dr. Gunn. Yes.

Senator Burdick. Would it be your intention to put them all in one center?

Dr. Gunn. No, no; the regional centers are to be preserved. They help the National Library's work, and they foster it, because they make it availale on a local level as well.

Senator Burdick. In other words, it would be sort of a nerve center, but have the indexes of all the other volumes in the country; is that right?

Dr. Gunn. They each serve a valuable function closer to the practicing physician in each area.

Senator Burdick. In other words, this plan that you suggest, it would make these volumes, these sources, available anywhere in the country?

Dr. Gunn. Well, the biotechnology center would be a tremendous bank of information that every researcher could draw upon.

And with your interest in books, Senator, I might say that the library is now engaged, along with the Library of Congress and Mr. Welch, in a great effort to try to preserve the books of the past which, as you may know, are in danger of crumbling due to acid paper.

That is another matter that is in our budget.

Senator Burdick. What I am saying is, you are not going to collect these volumes in one big center, but you are going to have them indexed and available?

Dr. Gunn. Well, no, the books will be in the National Library of Medicine, the books that are collected. Now, the regional centers serve not only functions in collecting books, but they also serve other functions, in the computer sphere which is becoming a very important part of the library's work.

Senator BURDICK. Well, if there is a hospital in Minneapolis, MN, that would like a book on a particular subject, it would be so cataloged and so indexed, Minneapolis, MN, would be able to get that book, regardless of where it was in the country?

Dr. GUNN. Yes, he would.

Senator BURDICK. Thank you.

STATEMENT OF FATHER T. BYRON COLLINS, S.J., GEORGETOWN UNIVERSITY

ACCOMPANIED BY:

DR. EDWARD J. BURGER, DIRECTOR, INSTITUTE FOR HEALTH POLICY ANALYSIS

MARY S. ALBERT, MEDICAL CENTER

Senator BURDICK. Our next witness is T. Byron Collins, Georgetown University.

Father Collins, welcome to the committee.

Father COLLINS. Senator, it's a pleasure being here. I will be very brief.

With me is Mary Albert from our medical center, and Dr. Burger from our medical center.

A series of topics. I will do one-line presentations of them.

First is the Higher Education Facilities Loan Program. In our testimony we request that it be kept open. It has been in existence since 1954. One of the best of the higher education programs.

Next, the National Library of Medicine, we support the request made by the witness just in front of us, that the National Library of Medicine be increased to $79 million, and support specifically the request of Congressman Pepper for his program in the National Library of Medicine.

Georgetown has been of service to the National Library of Medicine for 16 years. We have a function called the bioethics line, part of their computer program. The director, Dr. Lindberg, has now regularized that, so we do not need to testify in its behalf.

The other program from the Medical Center's point of view is the Health Education Assistance Loan Program. This is a program that is at no cost to the Federal Government.

It has a guarantee of the loan. We ask that it be kept at the authorized levels.

The next is advanced Nurse Training Program. We ask that the committee continue to fund it at the same level that it funded it last year.

And our last topic is an Institute for Health Policy Analysis. This is an information research analysis program that Georgetown has initiated.

It has grown in 5½ years. We have been of significant service to the Federal Government, as well as the health components of the Nation. And we ask for committee consideration of support for that.

And that ends my testimony, Senator.

Senator BURDICK. Do your associates care to make a comment?

Father COLLINS. Dr. Burger is the director of our Institute for Health Policy.

Dr. BURGER. Mr. Chairman, thank you very much. I appreciate this opportunity.

The institute was established nearly 6 years ago to provide service both to the public and the Federal Government on issues of national importance concerned with health.

It concentrates specifically on matters of health care technology, and on issues that become risks to health.

PREPARED STATEMENTS

It focuses substantially on uncovering risks to health and what they amount to, and therefore provides true opportunities for prevention of disease and health promotion.

Father COLLINS. Thank you, Senator.

Senator BURDICK. Thank you.

[The statements follow:]

Statement of Father William L. George, S.J., Assistant to the President, Georgetown University

Mr. Chairman and Members of the Committee, I am Father William L. George, S.J., Assistant to the President of Georgetown University.

I would like to ask the Committee to resist the Administration's proposal to sell the College Housing Loan Portfolio. In addition, I urge the Committee to support a continuation of the present level of loan authority of $60 million.

The College Housing Program operates a "revolving fund" whereby new loans are made with funds from payments on previous loans. Therefore, this program requires no budget authority and no new appropriations. However, selling the College Housing Loan portfolio will cheat the Government out of the real value of these assets. A portfolio of 3% loans payable over 30 years is not an attractive investment by today's market standards. The portfolio could only be sold at a tremendous discount, probably less than half of the total loan value of $2.3 billion. The Administration has even acknowledged this fact by including substantial "write-offs" in the proposed budget in order to compensate for discounted loan sales and prepayments.

Because all future payments would belong to the purchaser of the loans, the Government would no longer receive repayment income and would not be able to make any new loans. As our enclosed schedule shows, in the long-run the Federal Government would incur over $2 billion in losses of immediate and potential income. This would not appear to be in the best financial interests of the Government. By selling the portfolio, the Government would be trading slim current earnings for tremendous long-term benefits to the needs of higher education.

The House Budget Committee has not approved of the sale of these assets in its plan. I would like to ask this Committee to deny this part of the Administration's plan.

The Administration is also proposing to use unobligated portions of the loan fund to cover the operating costs of the program. To do so would frustrate the ultimate aims of the program. A more equitable approach would be to return to the revolving fund all unobligated balances which could then be used for new loans in the next fiscal year.

The need for money for academic facilities renovation cannot be overemphasized. Over 50% of higher education physical plant was built before 1960. Educational institutions have been forced to assume a greater responsibility for student aid, as Federal assistance for this has declined in recent decades. This financial burden together with the demands of inflation, energy costs and staff salaries have resulted in the deferral of the upkeep and repair of academic facilities. Despite minor decreases in overall college enrollment, many schools have experienced either no change or substantial increases in enrollment, which further magnifies the need for improved facilities.

Federal participation in financing academic facility renovation is needed. It is often difficult or impossible for schools to find loans for academic facilities that depend on tuition charges. If we hope to maintain a competitive edge as a nation, we must ensure that our country's excellent higher education systems have physical facilities conducive to intellectual and academic endeavor.

Furthermore, Federal loans in the College Housing program have acted as "seed money", stimulating almost five private dollars for every dollar the Federal Government has lent. In 1986, $57.4 million of Federal loans for college housing resulted in projects with a total cost of over $250 million. Many of these projects would not have taken place without the impetus of the Federal loans. Naturally, the economy in general, and in particular the ailing construction industry, benefit from this.

The College Housing Loan Program is a quality program that has always been shared by public and private colleges and that has benefited colleges and universities all over the country. The new Higher Education Law allows the program to address the problem of the nation's academic facility infrastructure.

On behalf of Rev. Timothy S. Healy, S.J., President of Georgetown University, I urge the committee to continue to support the College Housing Loan Program, and I thank you for this opportunity to testify.

Statements of Father T. Byron Collins

Mr. Chairman and Members of the Committee, I am Father T. Byron Collins, S.J., Assistant to the President of Georgetown University. I am accompanied by Dr. Samuel Harvey, Jr., and Mary S. Albert, also representing Georgetown. We would like to thank the Committee for this opportunity to testify in support of funding for the Bioethics Library and Information System in FY 1988 through the National Library of Medicine.

We would like to urge your support of the President's Budget proposal of $64,399,000, increased from $61,838,000 in FY 1987, for the National Library of Medicine, which sponsors the National Reference Center for Bioethics Literature (NRC) as well as many other programs of critical national importance.

The Ethics Library, founded at Georgetown University in 1973, was competitively awarded a $1.4 million grant in FY 1985 by the National Library of Medicine for the NRC's development as an extension of the Ethics Library. Commencing with the receipt of this award, the NRC has embarked on a program to actively disseminate bioethics information throughout the nation for consultation on such topics as surrogate motherhood, gene therapy,and withdrawal of nutrition and hydration from comatose patients. Some of its specific projects are:

(1) identification of over 130 bioethics organizations located throughout the world -- the first step in organizing an international network of bioethics libraries;

(2) provision of a toll-free telephone number that is currently responding to over 70 inquiries per month;

(3) the collection of over 150 syllabi of bioethics courses from undergraduate to professional levels--the nucleus of the Bioethics Curriculum Clearinghouse;

(4) the direct dissemination of information about the NRC's services to over 7,000 libraries; 2,000 hospital ethics committee members; and to the subscribers of journals devoted to bioethics and health policy issues.

The Bioethics Information Retrieval Service was similarly established following a competitive peer review process, and since 1974 has been continuously supported by the NLM as a comprehensive, cross-disciplinary information service to monitor the scattered literature on bioethical issues. This service has been made available for use by health professionals, policymakers, researchers, teachers and students, clergy and others with interest in the increasingly important and complex value dilemmas that we confront in the areas of health care and biomedical research. The primary instruments of supplying this information are the BIOETHICSLINE database, a function of the Bioethics Information and Retrieval System, and the Bibliography of Bioethics, the information indexed in both having been collected by the NRC.

In 1986 over 2,500 persons used resources of the NRC on site and the BIOETHICSLINE database was used a total of 600 hours via the National Library of Medicine's computer system. This latter figure represents a 66% increase in connect time in the past four years. This clear demonstration of the growing interest in bioethics points to the importance of providing information resources in a field of increasing public concern.

In FY 1988 $460,000 has been requested for the NRC and $525,000 for the Bioethics Information Retrieval System, for a total request of $985,000 for both activities..

Georgetown University provides approximately $2 million in addition from its own resources toward these programs.

In view of this, we request that the committee continue its support of this vital program as it deliberates the appropriations of FY 1988.

Mr. Chairman and Members of the Subcommittee, I am T. Byron Collins, S.J., Assistant to the President of Georgetown University. I am accompanied by Mary S. Albert, Director of Government Affairs at our Medical Center. We are delighted to be here today to testify before you on the FY 1988 appropriations for the Department of Health and Human Services. We will be addressing two topics:

1) HEAL. We come before you every year to discuss the Health Education Assistance Loan (HEAL) program. In this critical last-resort loan program, health professions students borrow their educational expenses from private lenders, with the Federal Government guaranteeing the loans. The loans have no direct budget expense: Private lenders provide the principal, the student lenders pay unsubsidized interest (90-day T Bills plus 3%), and the insurance premium for defaults.

We urge the Committee to reject the language proposed by the Administration which would cap the HEAL loan at $100,000,000, to require quarterly apportionment of HEAL loans, to require 20% risk sharing by the lenders, and to permit the Secretary of HHS to raise the insurance premium.

There is absolutely no question that health professionals will require the fully authorized amount of HEAL loans ($305 million) in the coming fiscal year. Annual administration requests simply do not recognize that this last-resort loan must be available to our students.

Similarly, the Administration proposal that lenders assume 20% of the risk is not realistic. Lenders will either leave the program, or will limit loans to only those students who can meet stringent commercial loan credit-worthiness--certainly not the intent of the legislation which seeks to find educational financing for those very students who lack financial resources. Furthermore, the students are paying premiums into the insurance fund to fully cover default.

Raising the premium of the insurance fund should not be permitted at this time. It is important that HHS fulfill the requests of the Congress to provide more timely and better data and data analysis on the HEAL program. Moreover, the new regulations, effective April 1, should significantly tighten up the administration of the program and improve present default rates. Even the brief report from HHS indicates that default figures are exaggerated, and that 30% of defaults are already in repayment.

We believe apportionment of the HEAL loan guarantees on a quarterly basis will interfere with the orderly processing of our students' loan applications. Disbursement is required each semester, but a single loan application can suffice for the year. Both lender and borrower should know at the outset the availabilety of the guaranteed loan principal, and not wait for quarterly loan guarantee disbursements.

In summary, the Administration's provisions on HEAL should be rejected, and the program should be continued as it is, as a sure, last-resort source of loans for health professions students.

2) Advanced Nurse Training. As with the HEAL loan, we come before you each year to request your rejection of Administration requests to savage training programs in advanced nursing. Once again, we have arrived at a time of nurse shortages (for example, our own University hospital is unable to fill its staff with US nurses and is forced to recruit nursing staff from Canada). This is hardly the time to reduce the modest support of advanced nurse training which trains the profession's leadership cadre. At Georgetown, our graduate programs--in midwifery, gerontology, and administration--have been very successful. We urge full funding to continue these programs in advanced nurse training: $16.7 million for Advanced Nurse Education; $9.5 million for Special Projects; and $12 million for nurse midwifery and nurse practitioner programs.
We appreciate the opportunity to appear to you today on these important programs and would be delighted to answer any questions you may have. Thank you.

3) National Library of Medicine. Georgetown University Medical Center urges the Committee's support for additional funding for the National Library of Medicine for a total of $79,107,000. In particular, we request support for $2 million increase for the Integrated Academic Information Management System (IAIMS) Project. The increase will allow NLM to support the implementation of working prototype systems in a few of the designated IAIMS institutions These prototypes, linking multiple institutional databases and information systems, may ultimately form the foundation for an interactive national biomedical information system.

We also believe that it is most important to eliminate the $500,000 ceiling on annual grant awards in order to allow participating institutions sufficient funds for IAIMS prototype development.

The revolutionary increase in biomedical information urgently requires support of a higher level of funding for the NLM. Thank you.

STATEMENT OF EDWARD J. BURGER, JR.

My name is Dr. Edward J. Burger, Jr. I am the Director of the Institute for Health Policy Analysis, Georgetown University Medical Center. I am pleased to be able to appear before the Committee to consider with you the role played by this Institute and the particular importance of its program and activities to the Federal government. Accompanying this brief statement is a description of the Institute's substantive programs for your information.

The Insitute was established to deal with health issues of importance at the national level. It is dedicated to the study and identification of national health issues before they become publicly recognized concerns. In much of its work, it is concerned with the medical-scientific basis for assessing risks to health and, in this way, plays a key role in identifying true opportunities for prevention of disease and premature mortality. The Institute provides a focus for research and a neutral, academically-based forum where public and private sectors and interests can be brought together.

The Institute has been in existence for approximately 5 1/2 years. During this period of time, its work on health care technologies has been quoted and used in the deliberations of both Houses of the Congress. The Institute has established itself, I believe, as a substantial resource and authority on the intersection of science and the law and its work on health risks in relation to compensation for disease, product liability and tort law reform have been used widely by private parties and by all three branches of the federal government. The Institute is currently assisting in meeting the Government's challenge concerning AIDS. It has contributed to a better understanding of the development of pharmaceutical products in an environment of industrial competitiveness. The work of the Institute is supportive of the goals of disease prevention and health promotion of the Department of Health and Human Services.

The Institute, at this point, seeks to fulfill its potential capacity. Accordingly, we ask the support of this Committee for an appropriation of $1,000,000 per year. This will permit the Institute to develop its full strength. There will be additional, substantial funding available from private sources.

STATEMENT OF HOMER R. WARNER, M.D., PRESIDENT-ELECT, AMERICAN COLLEGE OF MEDICAL INFORMATICS

Senator BURDICK. Our next witness will be Homer R. Warner, M.D., president-elect, American College of Medical Informatics, Kaiser Permanente Medical Program.

Dr. WARNER. Mr. Chairman and members of the subcommittee, I am not from the Kaiser Permanente. I am a professor and chairman of the department at the University of Utah.

And I would like to make a statement on behalf of and in support for increasing the budget for the research in medical informatics, which is largely funded, these days, through the National Library of Medicine.

In the testimony you have heard already this morning, it is apparent that there is a great proliferation of medical knowledge. And the difficult we face and must find a way to solve, is getting that medical knowledge in the hands of a physician when he is faced with a particular case that he needs to understand.

Now, the doctor faces quite a different situation that someone like, say, a travel agent who is looking up some information. He doesn't know what the problem is.

The books are organized by disease. The physicians present themselves by symptoms.

And one of the primary tasks of medical informatics is to rearrange information in such a way that the doctor can enter the complaints of a patient and get back advice as to what the likely cause of that is.

And then he can go to the source materials, such as the things that the library maintains, to find out more details about how to treat that condition.

Now, medical informatics concerns itself with trying to build models of the way people think. How do physicians organize information to make a diagnosis?

We and others, under support from the National Library of Medicine, have developed programs that are now operational in hospital settings that prompt physicians, that act like consultants to physicians, by presenting the appropriate information at the appropriate time to improve the quality of health care.

The Library, at this point in time, supports most of this kind of research. And yet they have no funds for next year to support any new projects.

All of their funds are allocated, and will be used simply to support ongoing projects.

Another great need is the support of people, trained people, in this field. The library has some training programs, about six of these, that support training of people who know both medicine and computers well enough to tackle this important task that is just coming to the forefront.

We have a tremendous opportunity with this rapid growth of computer technology to use that to solve our information problems in medicine.

And I urge that you continue the support of the library and consider the fact that its budget is not really adequate to handle not only the current grants, but any increased, any new applications that will come in.

I would also like to put in a word for the biotechnology program which is proposed under Senator Pepper's bill to support management of information that is coming out of the tremendous effort to understand genetic disorders.

This is a giant new field that is just coming to the forefront. And that information is duplicated. It is not going to be available in a timely fashion unless we support the informatics effort to rearrange this in the proper way to make it available to researchers.

PREPARED STATEMENT

I thank you for this time and opportunity to present before you.

Senator BURDICK. Thank you.

[The statement follows:]

STATEMENT OF HOMER R. WARNER

I am Dr. Homer Warner, Professor and Chairman of the Department of Medical Informatics at the University of Utah's School of Medicine and President-Elect of the American college of Medical Informatics. Thank you for the opportunity to participate in these hearings. I would like to speak about the importance of federal support for research in medical computing and information management in our health centers, and the essential role the National Library of Medicine plays in the dissemination of biomedical information.

In our information rich age, an unrelenting mass of data confronts the scientist. The struggle to conquer it takes on its own special dimension for the biomedical researcher, educator, and clinician since lives ultimately depend on its outcome. Keeping pace with the accelerated growth of biomedical information, transforming it into knowledge and finally to patient care requires increasingly sophisticated electronic information processing tools. The relatively new field of medical informatics joins computer and information science with the delivery of health care, and seeks to develop these new tools that will provide better ways to organize, retrieve, and use health knowledge.

The medical informatics expert recognizes that processing information faster is not sufficient. What is needed is more intelligent processing, logical aggregation of information, synthesis and analysis, and the development of knowledge systems that will assist in medical decision-making. Medical informatics' research has centered on how best to represent biomedical knowledge in computer systems, to access that knowledge, and to develop computing systems that can actually use knowledge to analyze clinical problems and help with diagnosis or to give advice about specific complex patient management problems.

I believe the investigation into how one can best manage research results to benefit the patient is an integral part of the Nation's entire biomedical research investment. If adequate resources for these investigations are not forthcoming, I believe the entire research investment will be compromised. Even now, current investments in developing ways to handle the results of our Nation's multi-billion dollar biomedical research effort are failing to keep pace with the information generated. This lack of investment is evident in the budget of the National Library of Medicine now before this committee. The NLM is the prime source of federal support for research in medical informatics, and yet the administration's budget proposal for the Library would not permit the funding of a single new research grant in this important area. In my opinion, an additional $6.2 million is required to adequately support investigator initiated research and to provide a nucleus for forming Centers of Excellence in medical informatics in our Nation's universities.

As important as research is in solving the technical problems in medical computing--problems of knowledge representation, common language systems, and machine to machine communications--an additional critical element remains in ensuring optimal use of biomedical research results for the benefit of the patient. Institutional restructuring to make possible the integration and effective use of all the complex information gathering activities within a health center must also occur. For that reason, the National Library of Medicine instituted a program to support the study, planning and development of Integrated Academic Information Management Systems. The program's concept involves the use of computer and communications networks to transform the various information bases of a complex medical institution into an integrated system. The goal is to link and relate the database representing academic information to individuals' and institutions' working information files. The initiative is a three phase effort bringing an institution through strategic planning and model development to an operational prototype state.

Several institutions, including our own, have completed our planning efforts and have succeeded with research and demonstration support to show the benefits and prove the feasibility of operational systems. Unfortunately, this program, so agressively and successfully pursued through its planning and development phases, has not been funded for the last critical phase of creating operational models. To support this effort and to bring to fruition the past investments would require an additional $4.5 million per year for this implementation phase.

Mr. Chairman, as a recipient of these planning and development grants, I can assure you that they have had an enormous and revolutionary effect on our medical center. The impact on patient care has been already significant. We greatly appreciate the past support of this committee, and sincerely hope you can find the means to see this program through to its desired objective of four or five operational models. We hope that the importance to our Academic Health Center will be evidence that this Integrated Academic Information Management System program is well conceived and responsive to an important need.

Before concluding my statement, I would like to express my appreciation and support for a bill introduced by Representative Claude Pepper that would establish a biotechnology information center as a component within the National Library of Medicine. The promise genetic research holds in understanding disease is extraordinary. However, the traditional methods of handling research results are simply not applicable to this field where information is being generated in quantities beyond that which can be managed. With appropriate resources estimated at $10 million per year, there is no doubt that a biotechnology information center in the NLM would make enormous contributions to making possible the full use of biotechnology information. In fact, the functions proposed for the center seem to be absolutely necessary to do the genetic research envisoned in the years ahead.

In conclusion, Mr. Chairman, on behalf of my colleagues, I respectfully ask that you recommend a budget that would permit NLM's important programs and initiatives to continue, and the exciting prospect of a biotechnology information center, to flourish. We request at least a minimal continuation of previous efforts in medical informatics and support for the successful culmination of the Integrated Academic Information Management System programs. We urge your recommendation of an overall budget of 89 million dollars for the National Library of Medicine to make these goals possible.

Thank you again for this opportunity to present my views on these important health information issues.

Senator Burdick. I am interested in this subject very much. And being a lawyer, I know what the value of a library is.

My question is, I am a country doctor out in the middle of North Dakota, and I have a patient with problems and various symptoms, how do I as a country doctor have access to this library that might lead me to make some decision on what is wrong with our patient?

Dr. Warner. Well, this is one of the challenges we face, how to get the knowledge to the man practicing on the site?

Computer technology has reached the point now where the hardware is affordable. We can put that in every doctor's office.

What we need is to have enough people trained in the medical knowledge area, that know the medicine aspect of it and at the same time, know something about computers, to arrange this information, and put it in formats so that it will be available in every physician's office.

If you look, even over my lifetime, the cost of computer services to do a particular job has dropped by a factor of about 25,000. That means you could buy for a dollar today what you paid $25,000 to do 20 years ago.

And that rate of change has not decreased at all. It is happening.

Our approach is that the computers are going to be free. We will have no difficulty in placing the hardware in any doctor's office that can use it.

Our difficulty is in taking advantage of that in medicine by taking people who know enough about the medicine to learn how to rearrange this in such a fashion that we can put current information at that doctor's fingertips, you see.

It won't be in the form of books. It will be in electronic form. It will be rearranged, so he can get a few symptoms, and he can get back something that is useful in managing that patient at that point in time.

At the LDS hospital in Salt Lake City right now, we have a program that is operational, not in an office but in a hospital setting, that makes over 80,000 decisions a day.

These decisions came back to the physician in the form of prompts. For example, if a doctor writes a prescription, that prescription is entered into the computer by the pharmacist when he comes around and picks it up.

If the computer knows anything about that drug, and can look in that patient's record and see that there are other facts that would indicate, based on the other knowledge that it has about that drug, it will come back and prompt the physician that he ought to change the drug, or he ought to reduce the dose, or whatever.

Physicians respond to that very favorably. They make the appropriate change. It keeps them out of trouble. And by the way, it also keeps them away from medical legal problems, because they don't make the errors.

It corrects them before the wrong drug is given, you see.

Senator BURDICK. But you are telling me now that a country doctor with the available technology, to wit the computer, will have available to him all the information that might be available to a large hospital in New York City or anyplace else.

It is available out there in North Dakota?

Dr. WARNER. It can be made available. That is correct. I do not mean to imply that we have solved the whole problem at this point in time.

We have prototypes running with a subset of the medical knowledge that works very well.

What we need now is a tremendous effort, research effort really, of people who are trained across both these disciplines, computers and medicine, who can assemble that, rearrange it in appropriate fashion, and build these tools that, you know, a few years from now, can be made available in Utah or South Dakota or wherever, you see.

Senator BURDICK. I wonder if you could send us a note or two and explain the procedure on this, how it would be available to a country county seat in North Dakota, for example. It would be very valuable.

Dr. WARNER. All right. Thank you.

STATEMENT OF DR. KIRK N. GELATT, UNIVERSITY OF FLORIDA COLLEGE OF VETERINARY MEDICINE, ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES, AMERICAN VETERINARY MEDICAL ASSOCIATION

Senator BURDICK. Our next witness is Dr. Kirk Gelatt, University of Florida College of Veterinary Medicine.

Welcome to the committee.

Dr. GELATT. Good morning, Mr. Chairman, members of the committee and staff.

I am pleased to speak for the American Veterinary Medical Association, and for the Association of Veterinary Medical Colleges and for the opportunity to present to the subcommittee our recommendations on the health and education program funding for fiscal year 1988.

The veterinary medical profession is an important contributor and resource in our Nation's health enterprise. We strongly support funding for functions 500 and 550, as set forth in the House budget resolution of April 9, and in the recommendations of the Senate Budget Committee.

The use of animals for research in recent years has been a topic of intense discussion. Nonetheless, the continued responsible use of animals for both teaching and research is critical for both the basic and applied biomedical research programs, and the development of drugs and therapies for both human and animal diseases.

We make a very strong plea for adequate funding for the animal resource program of the National Institutes of Health in both the Division of Research Services, and the Division of Research Resources.

We recommend that the latter, research resources, budget be increased by about 16 percent, to provide a total $63.7 million for fiscal year 1988.

This will permit improvement of existing laboratory animal facilities; support of regional primate centers; and permit expansion of training programs in support of an investigative support laboratory systems.

We strongly support efforts to strengthen the competitive grant system, which has resulted in one of the world's best and most effective and efficient research programs in the world.

We recommend approximately $4 billion for fiscal year 1988, which will provide funding for about 38 percent of the approved grants, and full funding of up to 7,000 new and competing renewal grants.

The veterinary medical community is also very concerned about increasing the funds available for research training. We estimate at least 450 new positions will require veterinary medical scientists by the year 2000, and to train this number will require 11 to 12 years and about $41 million.

The focus of these new training programs should be on the development and application of biotechnology to the broad area of animal health and food safety.

We support the current recommendation of the ad hoc committee on medical research funding, which is to add at least $21 million over maintenance of current research training programs.

We support a $13 million increase over the current $16 million small instrumentation grant program, approved by Congress for fiscal year 1987. This program has important benefits to permit a timely updating and upgrading of multiuser small research instruments.

PREPARED STATEMENT

Last, we have other comments relative to the educational aspects, but these have been entered for the record.

Senator BURDICK. Thank you very much.

[The statement follows:]

STATEMENT OF DR. KIRK N. GELATT

Thank you for this opportunity to present to the Subcommittee the recommendations of the American Veterinary Medical Association (AVMA) and the Association of American Veterinary Medical Colleges (AAVMC) on health and education program funding for FY 88.

The veterinary medical profession is an important player in our nation's health enterprise. We strongly support funding for Functions 500 and 550 as set forth in the House Budget Resolution of April 9 and in recommendations of the Senate Budget Committee. We strongly oppose the reductions which the administration is seeking in student loan programs and for biomedical research. Nothing can be more important to the future health of our country than maintaining a strong research base and the pool of talent necessary to cultivate that research.

NATIONAL INSTITUTES OF HEALTH

Animal Resources

In recent years, the use of animals in research has been a topic of intense discussion. The continued, responsible use of animals is critical to both basic and applied biomedical research as well as to the development of drugs and therapies for both human and animal disease. Use of these research animals benefits the people of our country and carries over important benefits to the health and welfare of America's livestock industry as well. Likewise, the knowledge gained translates into improved health for America's pets, which in turn contributes to better health for people. In light of the importance of animal research and research animals, AVMA and AAVMC wish to make a very strong plea for adequate funding for the animal resources program of the National Institutes of Health, in both the Division of Research Services (DRS) and the Division of Research Resources(DRR).

The proposed budget for animal programs in the DRS is minimally adequate; however, funding for the extra-mural programs in the DRR are desperately in need of an increase. We recommend that the DRR budget be increased by 15.6 percent, providing a total of $63.7 million for FY 88. This amount will allow for improvement of existing facilities, support regional primate centers, expand training programs, and provide for needed expansion of the diagnostic and investigative laboratory system.

Research Grant Funding

The competitive grant system is the heart of an effective and efficient research program; therefore, we strongly support efforts to strengthen the competitive grants system. It is our long term goal to see that these grants are awarded at the study section-recommended levels. We recommend approximately $4 billion for FY 88 which would provide funding for nearly 38 % of the approved grants and full funding of up to 7000 new and competing research grants.

Research Training

The veterinary medical community has a very high level of concern for increasing the funds available for research training. We estimate that a minimum of 450 new training positions will be needed for veterinary medical scientists by the year 2000 and that to train this number will require an 11-12 year program with a total cost of no less than $41 million. The focus of these new training programs would be on the development and application of biotechnology to the broad area of animal health and food safety. This funding recommendation is consistent with be those made by OTA, NAS and NSF for training of biomedical scientists. We support the current recommendation of the Ad Hoc Group For Medical Research Funding which is to add at least $21 million over maintenance of current research training programs.

Research Instrumentation

Our research institutions are experiencing increasing difficulty in maintaining adequate research instrumentation. We strongly recommend a $13 million increase over the $16 million small instrumentation grant program approved by congress for FY 87.

STUDENT FINANCIAL AID

We reject the President's proposal to terminate funding for health professions education and training and compliment the budget committees of both the House and the Senate for actions which would sustain funding of these critical programs.

Veterinary medical students are encountering increasing difficulty in financing their professional education. During the last three years the number of graduates whose debt exceeds $20,000 has increased from 26 percent of all graduates in 1983 to 50 percent in 1986. Work study is important to these students but because of curriculum demands few can take advantage of this program and for those who can it provides but a tiny portion of the financial aid package. Guaranteed student loans account for 65 percent of their financial aid package and the use of HEAL funds are of increasing importance. Despite relatively low starting salaries veterinary medical students continue to have very low default rates in all loan programs.

HEAL Program

We request that Congress once again exclude the HEAL program from the federal apportionment process. The insurance paid by the students continues to compensate for all defaults and this program is not a cost to the government.

Minority and Disadvantaged Student Programs

We urge that the appropriations level of $30 million be provided for the Health Careers Opportunity Program. The HCOP programs now being used by veterinary medicine are of critical importance in facilitating the recruitment, admission and retention of minority and disadvantaged students.

We also strongly support Senate Bill 769 and HR 954 titled "Excellence in Minority Health Education and Care Act". These bills if enacted would identify the Tuskegee University School of Veterinary Medicine as one of four health professions schools targeted to become a center of excellence. The contributions of this school are well known and further support in the context of this proposed legislation is most appropriate.

Loan Payback Deferment and Eligibility of Residents

In the technical corrections to the "Higher Education Amendments of 1986" we urge attention to two items of importance to all persons in training programs beyond the first professional degree.

Consistent with the language in the Conferees report, we request that an amendment which clearly states the eligibility of otherwise qualified residents in health professions and that they be allowed to borrow under the Guaranteed Student Loan and Supplemental Loan programs.

Secondly we request that individuals who are completing approved health professions residency training programs be allowed to defer repayment of student loans for up to two years.

Senator BURDICK. Our next witness is Dr. Henry Betts of the Rehabilitation Institute of Chicago.

Is he present? He is cancelled, I guess.

Our next witness will be Dr. Murray B. Gardner, professor of pathology, University of California School of Medicine.

Welcome to the committee, Doctor.

STATEMENT OF DR. MURRAY B. GARDNER, PROFESSOR OF PATHOLOGY, UNIVERSITY OF CALIFORNIA SCHOOL OF MEDICINE

Dr. GARDNER. Thank you very much. It is nice to be here.

I am speaking on behalf of the primate centers. I am also a researcher and educator, working 24 hours a day on AIDS research.

I have long been interested in the viruses that cause this kind of disease in animals. And when this disease had happened in man, it was quite logical that I devote pretty much full time and attention to it.

We are very active now in trying to make a vaccine, and better means of therapy. To do this, we are totally, absolutely dependent on using monkeys.

I am not referring here to chimps. You have heard that chimps are the only animals that are susceptible to the human AIDS virus, but there is still a great need for using macaques, rhesus macaques, which are smaller monkeys and can be housed in your primate centers, and have been studied there for many years.

Macaques are indispensable every bit as much for making an AIDS vaccine and immuno-therapy as they were for making polio vaccine, yellow fever, and measles vaccines.

The reasons are that the macaque has a virus that is very similar to the human AIDS virus, and serves as a good model to test out vaccine approaches. Before we put things in humans, we have to try them in animals.

The macaque also is now being found to be susceptible to certain versions of human AIDS viruses from parts of the world from West Africa, which now indeed will infect macaque monkeys. They even resemble the macaque virus.

So we need to use macaque as an animal in which to grow certain of these human viruses to test our immune therapy and immune prevention.

And finally, we must use the macaque immune system as a reflection of the human immune system if we are to develop the ability of different vaccine preparations to generate protective immunity.

You cannot rely on rats and mice and small animals; you must use a primate immune system to reflect the human immune system.

Now, you have seven primate centers which you have supported very well through the DRR, and these have done a bang up job. But the problem is, they were not made to handle this AIDS problem.

They do not have adequate biocontainment facilities for housing the animals in appropriate safety containment, and the laboratories there for the scientists to work together.

I have a big team working with me, which is a reflection of industry, government, academia. We are well funded. We are going to be better funded.

We cannot do anything more research-wise with the money you give us if we cannot house more monkeys in appropriate facilities.

Why can we not use the current facilities? Because we cannot build new facilities. There is a law, somehow, that prohibits NIH from granting new building funds.

The word renovation has been stretched to the hilt, so we are putting up temporary prefab things. But they will not do the job that we need done in terms of housing these animals.

So the specific plea is not only to continue your support of the primate research centers, which is a sine qua non, but to make it possible through new legislation to have building funds allocatable by NIH so that we can attach a wing to the building and put our animals in appropriate biocontainment; put our critical mass of scientists in the same place so that we can get on with this important research.

Thank you.

Senator BURDICK. In other words, you need more animals and more buildings?

Dr. GARDNER. Right. We need to breed those animals, also. We cannot import them as readily as before.

We can breed them, but we have to breed them very carefully, so we know about the viruses they have in them. So we need more breeding facilities, but we certainly need buildings to work on them in.

Senator BURDICK. Well, I understand from staff that there is no prohibition in the law. The only problem we have is money, lack of authorization.

Senator BURDICK. Lack of authorization. All right, well, whatever that takes, then, it takes new Federal legislation to give NIH the ability to give DRR the money to give to the primate centers.

Senator BURDICK. Can you project in the future? How are we doing?

Dr. GARDNER. I think we are doing fine. I think that in California, particularly, we have a mini-Manhattan project already off the ground, with a coordinated group of people in all the University of California divisions pulling together with certain industrial groups, with Jonas Salk helping to orchestrate it from his vantage point.

And I think that we can actually put something very useful together very soon. But a limiting factor is the ability to have the animal models to test in.

Senator BURDICK. Jimmy Stewart was invited to come over and see some friends in a picture I saw a number of years ago. And he asked one question: When? The question is, when do we get a breakthrough?

Dr. GARDNER. Everyone wants to know that. And of course, I'm always told to never give a timeline, because of false expectations.

But I would say that within 2 to 3 years we will have something that works, and I think we will be testing material before the end of this year in humans in this country, not only in people that are not infected, but will probably be using immuno-therapy, vaccine like materials, in people that are out there already infected, if you will, but still relatively healthy, trying to maintain that state of health and keep them from getting the disease.

PREPARED STATEMENT

So we are very optimistic, but we have to keep the ball rolling.

Senator BURDICK. Thank you very much.

Dr. GARDNER. Thank you.

[The statement follows:]

STATEMENT OF DR. MURRAY B. GARDNER

I am Dr. Murray B. Gardner, Professor of Pathology at the University of California, Davis, School of Medicine. I am here representing the Regional Primate Research Centers Program.

May I first take this opportunity to thank the members of this Committee for the support and recognition you have given the Primate Centers Program. Research at the Primate Centers has contributed greatly to our knowlege and understanding in the areas of cardiovascular diseases, maternal/infant relationships, diseases of the newborn, mental retardation, reproductive biology, infectious diseases, particularly AIDS, and diseases of the central nervous system. Quoting from a document which addresses the immediate and long range financial needs of the primate research centers, prepared by the Office of the Director of the N.I.H., "The numerous contributions made by the Centers during the past 20 years . . . leave little doubt of their importance to the health and well being of mankind." In addition to research on human health and disease, the Centers study naturally occurring diseases of primates, methods for husbandry and care, and breeding techniques to increase the supply of primates. Indeed, research in these areas will help to prevent many species from extinction.

Another crucial problem, which is well known to all of you is AIDS. This disease has been the subject of concern by the Congress as well as by the N.I.H. and the medical community. Last year, the National Academy of Sciences organized a Blue Ribbon Committee to address the extent of this problem and the manner in which it is to be resolved. Their report is contained in a document entitled "Confronting AIDS, Directions for Public Health, Health Care, and Research", National Academy Press, Wshington, DC, 1986. Under the topic of future research needs, the committee felt that a most important concern is the development of appropriate primate models.

> "Animal models that reproduce or mimic the consequences of HIV infection in human beings can play a crucial role

> in improving the understanding of disease pathogenesis and in the development and testing of antiviral drugs and vaccines. However, no completely analogous animal model for HIV infection and disease is now available.
>
> The most relevant and promising animal models are provided by nonhuman primates. Therefore, the nation's primate centers should be improved to permit the expansion of the primate populations available for AIDS-related research, the development of appropriate biocontainment facilities, and the education of appropriately trained investigators."

It is also important to keep in mind that progress in research in the field of cardiovascular diseases will be dependent to a great extent upon the availability of primate models. While considerable progress has been made in the battle against cardiovascular diseases, these still remain the Number One health problem facing the country. Because of potential problems with species differences, studies in primates with models of cardiovascular diseases will be invaluable.

Finally, the Centers provide unique facilities and resources to scientists from the entire biomedical community whose support by the National Institutes recognizes the national character of the health problems they pursue. A typical Center among the seven is currently engaged in active projects with 127 investigators representing 37 institutions from their region as well as other areas of the country and abroad.

The long term needs of the Primate Centers have in part been brought to this Committee's attention in the past and through your support progress has been made in maintaining and upgrading the facilities and resources for animal care and research.

We must, however, continue to address Primate Center needs in direct reference to the currently urgent problems they are pursuing in Public Health Service supported research,and the legislated requirements for exemplary animal care. We must continue progress toward breeding adequate numbers of primates. In fact, the major limiting factor in getting on with funded AIDS and cardiovascular research is the inability to expand facilities. The investigators of at least three of the centers have acquired substantial grant support for research in these two pressing areas, but are currently limited by the inability to expand their current facilities to house the additional animals and staff needed. One approach that might be considered is allowing part of the budget to be used for construction of additional facilities which can be thoroughly justified for specific national level programs.

With respect to availability of primates for research and the depreciation of the physical resources to support this research, this country is in many ways in poorer shape today than a decade ago. Demands on existing facilities exceed the available space and the scarcity of primates leaves many government funded programs unfulfilled. This problems is particularly acute in light of recent decisions from several other countries to reduce or eliminate export of primates to the United States.

Additionally, two years ago Congress passed new legislation, Public Law 99-198, title XVII, Subtitle F., commonly known as the "Improved Standards for Laboratory Animals Act" which was signed by the President on December 23, 1985. The full impact of this legislation is yet to be determined, but without any question the regulations now being formulated to implement sections of the new law pertaining to nonhuman primates will impose a major financial burden on the Centers to provide modified caging and housing, and will simultaneously reduce our Nation's primate resources -- resources which, as I have stated, are already thin.

I urge this Committee to review the Primate Centers' budgets such that every effort is made to provide adequate support to meet NIH policy and the new Federal legislation. I fully realize the difficult time and the budgetary responsibilities facing Congress, but the Primate Centers Program is small and can ill afford a reduced appropriation.

Congress showed wisdom in the creation of these Centers, and the Centers have in turn lived up to their responsibilities. It is a program to which we can all look with pride.

STATEMENT OF DR. HOWARD F. TAGER, NATIONAL DISEASE RESEARCH INTERCHANGE

Senator BURDICK. Dr. Howard Tager, National Disease Research Interchange.

Dr. TAGER. Thank you very much, Mr. Chairman, and members of the committee.

I am professor and chairman of the Department of Biochemistry and Molecular Biology at the University of Chicago, and have been associated with the NDRI since its founding in 1980, and since its development of systems allowing the research use of human tissue only a year later.

I am also a biomedical researcher who has relied on the NDRI for tissues for use in diabetes research and in research on hormones of the human pancreas.

On behalf of the NDRI, let me express our appreciation for this opportunity to present our views on fiscal year 1988 appropriations for the National Institutes of Health, and on the importance of human tissues in biomedical research of all kinds.

Research needs in this centennial year of the NIH are great, in all categories, but especially in the area of research resources.

Such resources are large scale initiatives that are beyond the grasp or ability of an individual investigator, but which are critical to the research activities of many.

They are, in fact, the shared base of national research programs and include sophisticated instrumentation, centers for clinical investigation, facilities for the study of animal laboratory sciences, and so forth.

There is a new category of research resource, however, that I would like to present to you, and that is, the provision of human tissues for biomedical research.

There can be no question that the best model for research in many cases on the diseases of mankind is the species closest to the human in terms of normal physiology and disease susceptibility.

That species is in fact the human, and just now it is beginning to be possible to investigate human tissues in the context of broad biomedical research initiatives.

Such initiatives confirm, augment and extend those very important ones involving animal models and cultured cell systems of various sorts, and in short, permit the investigation of the most real of circumstances, using the most pertinent of biological systems.

The NDRI has evolved with a single goal: To retrieve, preserve and deliver to biomedical researchers human tissues as a resource for their investigations.

The NDRI provides the know-how, the coordination and the people to make such an endeavor not only possible, but available to researchers nationwide.

The NDRI is indeed a prototype for these complex, detailed methods and mechanisms. It has in fact so far provided about 27,000 individual samples of more than 100 different types of human tissues to nearly 300 biomedical researchers across the country.

It coordinates the activities of 200 organ procurement agencies, eye banks, and hospitals, and provides normal and disease tissues that are carefully and exactingly prepared, according to many different—hundreds of individualized research protocols.

The real product of its activities, new information on human biology, has been applied in the study of 75 different human diseases. That includes cancer, diabetes, cardiovascular disease, kidney disease, cystic fibrosis, and eye disease.

Given the demonstrated scientific, economic and humane soundness of biomedical research activities, we believe that increased appropriation levels for the National Institutes of Health and the Division of Research Resources should be a national priority.

Given the demonstrated value of biomedical investigations involving the use of human tissue, we also believe that the NDRI is most appropriately considered as part of our national system of research resources.

It, therefore, seems appropriate for the National Institues of Health and the Division of Research Resources, in particular, to be the official and permanent home of the NDRI.

PREPARED STATEMENT

On behalf of the NDRI, I wish to thank you for this opportunity to present our views. I will, of course, be glad to answer any questions.

Senator BURDICK. Thank you very much.

[The statement follows:]

STATEMENT OF DR. HOWARD F. TAGER

Mr. Chairman and Members of the Committee: I am Howard Tager, Ph.D., Louis Block Professor and Chairman of the Department of Biochemistry and Molecular Biology of the University of Chicago School of Medicine. I have served as Chairman of the NDRI Steering Committee for two years and am now Chairman Emeritus of the program. I have been associated with NDRI since its founding in 1980 and for the design of this prototype system. I have used human tissue regularly in Diabetes research into the identification isolation and anaylsis of various hormone-related peptides from pancreatic tissue.

On behalf of NDRI, let me state our sincere appreciation for this opportunity to present our views to this Committee on fiscal year 1988 appropriations for the National Institutes of Health and particularly, the Division of Research Resources.

This year marks the centennial of the National Institutes of Health, and it is clear that the NIH has proven itself as an effective force in the national and international Biomedical community. Through NIH we have learned the research investment of the U.S. is responsible for the tremendous scientific strides taken during the last 100 years of scientific advancement in our country.

Indeed, we know the excellence of science today is dependent upon investigators having access to sophisticated instrumentation, well-equipped laboratories, information about new technologies, clinical research centers for the application of laboratory advances to human health care, large capacity computers, and the availability of biological materials and models critically needed for the study of human disease. The Division of Research Resources through its five extramural programs is the primary component within NIH which provides support for these type of research resources.

These five programs provide a variety of needed support. The clinical research program supports general clinical research centers located throughout the country. These centers provide an optimal setting for controlled investigation by clinical scientists supported by the NIH and other organizations, and they encourage increased collaboration among investigators in the basic and clinical sciences.

The Biomedical Research Technology Program provides support for the development of major instrument facilities and the latest technological applications from the fields of physical sciences, mathematics, and engineering. In addition to developing new research technologies and methods, this program helps to alleviate instrumentation shortages and obsolescence in laboratories conducting federally supported biomedical research.

The Laboratory Animal Sciences and Primate Research Program supports resource activities which make use of laboratory animals and other biological models in order to make their use more efficient and more effective. The Program also supports diagnostic laboratories, special non-animal biomedical models, and other activities that support NIH categorical programs.

The Biological Models and Materials Resources section was established in 1985 within the Division of Research Resources to develop and support the use of non-mammalian models in biomedical research. This section has assumed leadership in the development of the NIH plan required by the Health Research Extension Act of 1985 to develop research methods which do not rely on animals.

Last year Congress gave the NDRI a unique challenge when it added $750,000 to the NIH budget in order to support our work.

In essence, our program is the only one in the world that coordinates the "whole process" procurement of human tissues and organs, and preserves and delivers these tissues and organs to researchers throughout the country. NDRI has made it possible for investigators who never had access to human tissues to now obtain a regular supply. We are now working hand-in-hand with the Division of Reserach Resources to serve the needs of all the Institutes at NIH - A new survey shows that of the researchers we serve, over 90% are NIH funded researchers.

In its 1985 report entitled, "Models for Biomedical Research, A New Perspective," the Committee on Models for Biomedical Research commented that for many scientific problems the best model for research is the species closest to the human in terms of its taxonomy and physiology. Clearly, this conclusion underscores what scientific experts tell us: "Human tissue is vital in its use as an alternative resource to animal systems and organs."

Not only is human tissue more easily applicable to the human condition, but for most of the major diseases very few, if any, animal models exist. Thus, human models are sorely needed to explore diseases like cystic fibrosis, lupus, diabetes, and AIDS. The cures for many of these tragic diseases may very well depend on the human model and on the various disease tissues which can be retrieved for research. The following are only a few among the 70 vital disease areas serviced by NDRI.

- NDRI is the sole source of Human Pancreas for Islet cell Transplant clinical trials which we, who are parents of Diabetic children pray will be a new treatment or cure for Diabetes.

- NDRI is assisting in providing lungs for Hyaline Membrane Disease Research.

- Researchers are using human kidneys for the first time, in kidney research, which are procured for transplants but cannot be used.

- NDRI is supporting eye research. When the Cornea is taken for transplant the back of the eye is divided into 4 or 5 parts and delivered to researchers.

- NDRI is supporting cancer research - A major new cancer initiative is now providing human cancer tumors of all kinds to Cancer Researchers.

The world of resources for the researcher is exploding - it is in revolution. For the 100 years of NIH research, the core of research advances have been made utilizing animals. The question emerged time and time again, "Does what happens in a mouse, happen in a human being?" Now, for the first time scientists have a way to use human tissue and organs to corroborate their animal results.

Indeed, the NDRI procurement networks are a vital link to the successful transfer of human tissues for research. Currently, NDRI maintains contact with 19 hospitals, 50 eye banks and 92 organ recovery programs to procure tissue for research and transplant. Frequent and continued interaction with organ recovery, eye bank and hospital personnel is NDRI's policy. To date, over 100 human tissue types have been supplied to research investigators studying such diseases as diabetes, retinitis pigmentosa, cardiovascular disease, cystic fibrosis, and glaucoma. In all, NDRI has procured 27,000 tissue samples for research.

In the last 100 years, scientists have relied on animals to conduct important research. In the last few years, new resources have appeared including Cell Lines, Sera Banks, Hormones, Reagents, Hybridomas, Fibroblasts and Human Biological Data Banks. If science is to continue to advance, we must vigorously pursue the alternatives offered by the human model. It is an approach whose time has come.

Together the DRR and NDRI are fulfilling Congress' mandate to "develop more sophisticated systems and research models which do not rely on the use of animals." (Senate Report 99-408, p.408).

Given the demonstrated economic soundness of biomedical research activities, increased appropriation levels for NIH, and particularly the Division of Research Resources, should be a national priority. NDRI believes that in order for the Division of Research Resources to be able to continue its mandate and provide the leadership which is crucial to our national research effort, an appropriation level of $387.3 million is necessary for fiscal year 1988 a 70 million dollar addition. We also request that $3 million of this appropriation figure be designated toward the work for NDRI, in order to expand to meet the needs of NIH researchers in all disease categories.

The design of NDRI included that the appropriate home for the National Disease Research Interchange would be the National Institutes of Health. Congress in its wisdom, appropriated monies to make that possible. We applaud the foresight of the Appropriations Committees, the Congressmen and Senators, who support Biomedical research and know the value of corroboration of animal research, the importance of having an alternative to animals in research into diseases for which there is no animal model. It would be our honor to continue to serve the nation and the original aim of the designers of NDRI, this prototype, very simple, yet revolutionary system which has emerged as the first new research resource in Biomedical research in the last 100 years.

On behalf of NDRI, I thank you again for allowing us this opportunity to present our views. I will be happy to answer any questions.

STATEMENT OF CHRISTINE STEVENS, SOCIETY FOR ANIMAL PROTECTIVE LEGISLATION

Senator BURDICK. Our next witness will be Christine Stevens, Society for Animal Protective Legislation.

Ms. STEVENS. I am delighted to hear what the last witness had to say. I am representing the Society for Animal Protective Legislation, and you have my testimony.

Senator BURDICK. Could you bring that mike a little closer?

Ms. STEVENS. If my testimony could be put in the record, I would like to make a few additional comments.

My testimony is directed toward the development of alternatives to laboratory animals. And two of the speakers this morning have made such excellent statements, Dr. Gardner, of course, speaking of the use of human tissues, which are so extremely valuable, and have not been recognized as they ought to be.

We certainly want to support his request.

We would also like to support the request of Dr. Gunn for an increased $10 million for the National Library of Medicine for improving the distribution of information, because that again is an extremely important way of reducing the number of animals used for research, while increasing the effectiveness of the research.

So those are most encouraging proposals.

Now I would like briefly to go over the highlights of my own testimony.

NIH has issued a program announcement for projects and alternatives, that is following section 4 of Public Law 99–158, which directed them to establish a program, a plan for methods of biomedical research and experimentation which do not require the use of animals; which reduce the number of animals used in such research; or which produce less pain and distress in such animals than methods currently in use.

Their proposal is welcome. It would be even more meaningful if specific funds had been set aside for successful applicants.

As it stands, there is no obligation or assurance that NIH will fund any of the programs received in response to this announcement.

Proposals that do come in will be at some disadvantage, because they will be reviewed by the already established study sections who review the general pool of grant applications.

Thus, it would be better to have an RFP with a special review committee established, whose charge would be solely to review the projects on alternatives.

They would know that special funds are assigned, and would see that the most meritorious receive funding.

We urge the subcommittee to recommend an appropriation of $5 million to realize the intent of the law.

The plan, which has been issued, does note within its own statements that there is no focus program to develop nonanimal models for research; and that is needed.

Mr. Chairman, I see I have gotten to the red light, but could I just say one word more?

That is, we recommend a validation study by the Food and Drug Administration of alternatives to the Draize test. There are more than 30 methods researched by scientists that are out there to validate them.

Some people say it will cost $1 million; others say it could be done for less.

PREPARED STATEMENT

It should be done now, and we urge that you appropriate funds to make that possible.

Thank you very much.

[The statement follows:]

STATEMENT OF CHRISTINE STEVENS

NIH Research

On behalf of the Society for Animal Protective Legislation, I wish to express support for appropriations to implement Section 4 of Public Law 99-158 directing NIH to establish a plan for "methods of biomedical research and experimentation which do not require the use of animals; which reduce the number of animals used in such research; or which produce less pain and distress in such animals than methods currently in use" and for validation, development and training in the use of such methods.

NIH has issued a program announcement for projects on alternatives and a 6-page plan. This welcome action would be even more meaningful if specific funds had been set aside for successful applicants. As it stands, there is no obligation or assurance that NIH will fund any of the proposals received in response to this announcement. Proposals that do come in would be at some disadvantage because they will be reviewed by the already established Study Sections who review the general pool of all grant applications. To compete against regular research grants in Study Sections not alert to the needs for alternatives could lead to failure.

Better would be a Request for Proposal (RFP) which would mean that a special review committee would be established whose charge would be solely to review only the projects received on alternatives. If there were an RFP, there would also be some set aside funds. The special review committee would know that specific funds are assigned and would see that the most meritorious are funded. This review system would work better than scattering the proposals throughout 50 or so Study Sections. Also, there would be far greater assurance that work on alternatives would receive funding. We recommend that NIH assign specific funds this and every future year to fund projects mandated under Section 4 of PL 99-158.

We urge this distinguished Subcommittee to recommend an appropriation of $5 million for FY88 to realize the intent of the law.

The NIH outline of a plan for implementation of this section makes a number of helpful suggestions but does not come to grips with the real world. It speaks of a "state of the art consensus conference" as "a possible final objective of this portion of NIH's plan." While conferences may have their place, sponsorship of good new work on alternatives would go much farther to achieve the purposes Congress had in mind in including Section 4 in the NIH reauthorization.

The plan itself concludes with a paragraph beginning, "The committee noted that while NIH spends considerable monies on projects that do not use animals, there is no focused program [underlining supplied] to develop non-animal models for research." Despite this statement, the plan provides no encouragement for any new developments.

FDA Validation Study

There are now some 30 methods researched by scientists to substitute for the acutely painful Draize test in which test substances are dropped into the eyes of conscious rabbits. The Food and Drug Administration requires the Draize test. It should fund a validation study to make possible the use for regulatory purposes of one or more of the existing methods. I am advised that such a study could be done for $1 million. On behalf of the Society for Animal Protective Legislation, I urge this subcommittee to recommend an appropriation of this amount.

Benefits to the Public Health

Development and validation of alternatives can provide major benefits to human beings at the same time that they prevent needless suffering by test animals. An illustration is the recent commentary in *Nature*, "Cost-effectiveness of short term tests in carcinogenicity." The sub-heading states, "Most chemicals to which we are exposed are not properly tested for carcinogenicity. The latest methods of *in vitro* testing provide a way of screening with sufficient accuracy to remedy the situation." Within the body of the article we find, "at present, decisions are made based primarily on long term animal bioassays which cost more than $1 million for each chemical tested and take 2-4 years." Not surprisingly, the authors state, "Testing 50,000 chemicals in long-term animal bioassays is neither feasible nor cost-effective." They further state, "Short-term tests are inexpensive to replicate and provide information about dose-response relationships and mechanisms of action of chemicals rather than simply counting the numbers of tumors in exposed animals."

In describing the *in vitro* test batteries, they write, "Every test was found to be of value in predicting carcinogenicity with classification accuracies up to 81% ... Long-term bioassays may well offer no greater predictive accuracy; among 245 National Cancer Institute bioassays, 55 (22%) were judged inconclusive or equivocal."

Thus, development of non-animal tests has made it economically feasible to investigate in a systematic manner the tens of thousands of chemicals to which the public is exposed. This Subcommittee would do well to encourage the Department of Health and Human Services to undertake a program to identify unrecognized carcinogens through in vitro testing. This would be an important public health measure.

Non-animal methods can be important in seeking cancer cures, too, and here the National Cancer Institute is forging ahead with what The New York Times in a banner headline December 23, 1986, describes as a "Major New Strategy." The subhead reads, "Screening Thousands of Substances, Standard Mouse Gives Way to Technology." Quoting Dr. John A. R. Mead of NCI's drug development division, the article states, "The live mouse screen is just not producing action against the major tumors." The mouse-based screen will be phased out this year. Though mice will still be used to test for toxicity and effectiveness, the numbers will be greatly reduced, the article notes, "... the new method is 'disease-oriented' in contrast to the old 'compound-oriented' approach that was good at finding chemicals with certain anti-tumor properties but poor at finding drugs that worked in patients with most kinds of cancer."

Both computers and cell cultures, two classic alternative methods, are being used. "In the new strategy, the first step will involve not mice, but human tumor cells growing in test tubes ... The ability to maintain the necessary human tumor cell lines has improved, and an automated method has been perfected for reading and analyzing the results of the screening system. Without automation, large-scale use of the method would create a logistical nightmare since 10 million or more individual tests will be involved each year." This is a major speed-up. In the past thirty years, 400,000 chemicals have been screened mainly on mice suffering from leukemia, but though drugs were found that acted against these cancers in mice, chemical trials with human lung cancer victims have been disappointing.

The nation needs to fund original thinkers to bring additional alternative methods to light, to develop and implement them for the benefit of the public health. To reiterate, we urge that 1) $5 million be appropriated to the NIH for the development of methods that can replace vertebrate animals, reduce the numbers used, or reduce the painfulness of that use, and 2) $1 million be appropriated for validation by FDA of an alternative to the Draize rabbit eye irritation test.

In closing I would commend to the subcommittee's attention the recently published Proceedings of the international seminar, "Chemicals Testing and Animal Welfare" under the patronage of the Organization for Economic Co-operation and Development (OECD). This important seminar attended by leaders in the field shows clearly the great need for research and development of the new methods which reduce or eliminate the use of animals and make use of such systems as described in the articles cited.

Senator BURDICK. Preceding you was a doctor who described his fight against AIDS. And he asked for more money for purchase of monkeys, and places to house them.

Do you have any comment on the research with monkeys?

Ms. STEVENS. Well, first of all, I was very pleased to hear that he was not asking for chimps, and places to house them, since that has certainly been a very questionable matter.

And I have read, for example, in an editorial in Nature, that there is no justification for using chimpanzees on AIDS.

I am too little of an expert, Mr. Chairman, to comment on this new work with macaques. Our organizations are not opposed to the needed use of laboratory animals.

We are seeking a reduction in their numbers. We think that in many cases that use is not necessary; that it has been simply a tradition.

And I certainly would not wish to say that the monkeys should not be used if that is really necessary. And I am not an expert, so I leave that to the discretion of the committee, but would only suggest that it be very, very carefully examined.

That is the important thing. And when the construction is done for the housing of these macaques, that they be given proper housing.

We must remember that the law that was passed in 1985 calls for space, environment appropriate for the psychological wellbeing of primates. So that any new funding for primates must take that into account, and it is very, very important.

Senator BURDICK. Why do you oppose the use of chimps, and not oppose the use of other animals of that nature?

Ms. STEVENS. Well, it is not that we only oppose the use of chimps. It is just that much more difficult to manage chimps.

The chimpanzee plan for increasing the numbers that NIH has put forward is full of terrible flaws.

Chimpanzees are incredibly close to human beings. And if you start sort of factory farming chimpanzees, the baby chimps never are going to grow up to be able to be mothers.

They are just going to have to be taken away. Then you are going to have to hire humans to take care of the babies, because the chimpanzee mothers have been kept in small cages. They have not had the proper socialization. They would not know what to do.

So that whole big area, which NIH has taken some of the AIDS money for that purpose, that was not a good idea at all. And it is a lot easier to provide appropriate, spacious comfortable places for a rhesus macaque than it is for a chimpanzee.

Senator BURDICK. As I understand your answer, it is that a chimpanzee is of course an animal, but it is more human than other animals. Is that right?

Ms. STEVENS. It is the closest one. That is right. And the biochemistry is so close that you can hardly tell the difference.

And you have to remember that behaviorally they are also—and that is not to denigrate the macaques. They are extremely interesting animals too, and need the greatest appreciation.

It is just not quite so hard to take care of them.

Senator BURDICK. Thank you very much.

Martin L. Stephens, Humane Society of the United States.

STATEMENT OF DR. MARTIN L. STEPHENS, THE HUMANE SOCIETY OF THE UNITED STATES

Dr. STEPHENS. Mr. Chairman and members of this subcommittee, I am Dr. Martin Stephens of the Humane Society of the United States [HSUS].

On behalf of the HSUS's 550,000 members and constituents, I appreciate this opportunity to comment on certain programs of the National Institutes of Health.

Because the HSUS is concerned with animal protection, I would like to address the three issues this morning: pound seizure; NIH's chimpanzee breeding program; and alternative methods of research that Ms. Stevens just mentioned.

Pound seizure is the practice of taking dogs and cats from animal shelters and using them in experiments. The HSUS is opposed to this practice, and we ask this committee to help us end it, by prohibiting NIH from using their money to fund projects that use shelter animals.

Animal shelters are meant to be refuges for homeless animals, not warehouses for laboratory specimens. Shelters rely on their public cooperation to carry out their valuable community services, and this cooperation can plummet when shelters are required to release animals to researchers.

Researchers do not need former pets to conduct their experiments. Former pets comprise less than 1 percent of the animals used in biomedical research. And there is plenty of scientific evidence to suggest that these animals do not make good research subjects because of their unknown and variable medical backgrounds and genetic endowments.

The reason why pound seizure continues is that pound animals are cheap to purchase. But this is a false economy. There is a University of Oregon study that shows that it is in fact more costly to use pound animals than purpose bred animals in certain types of research.

Pound seizure is already prohibited in 11 States and 4 foreign countries. And the HSUS is asking this committee to help us end this practice throughout the United States.

The NIH recently embarked on an ambitious chimpanzee breeding program that we heard a little bit about before, and it is to ensure a steady supply of chimps for research.

But unfortunately, the plan does not address some very serious humane issues. For example, there is no provision made for the retirement of unwanted animals. And these are very long-lived animals.

So this raises the spectre of these animals being killed for expediency.

Now, Congress rejected this plan in 1986, but NIH was undaunted and used $4.5 million from its AIDS budget to fund the plan.

So we are asking that if NIH comes before you to request additional money for the program, that you deny this request until they address these humane issues.

And also, if they continue funding the program with AIDS money, that you put restriction on such spending.

The final topic that I want to mention was already touched upon by Ms. Stevens, alternative methods of research. She mentioned that Congress directed the NIH to come up this plan for humane methods of research.

And we also applaud this congressional directive, and we applaud NIH's plans to develop these kinds of methods. But we also are dismayed that NIH did not earmark any special funds for this program.

PREPARED STATEMENT

And we, as did Ms. Stevens, would like to point out that we feel this committee should have NIH earmark special funding so that the development of alternative methods of research can receive the attention that it deserves.

Thank you for this opportunity to testify.

[The statement follows:]

STATEMENT OF DR. MARTIN L. STEPHENS

Mr. Chairman and members of this Subcommittee, I am Dr. Martin Stephens, Director of Laboratory Animal Welfare for The Humane Society of the United States (HSUS). On behalf of our 550,000 members and constituents, I appreciate this opportunity to address our concerns about certain programs at the National Institutes of Health (NIH). The HSUS has asked me to discuss these issues because I hold a Ph.D. in biology from the University of Chicago and have conducted federally-funded research.

Because the HSUS is concerned with animal protection, I would like to address the issues of: 1) pound seizure, 2) NIH's chimpanzee-breeding program, and 3) the elimination of inhumane uses of animals in research through the development of alternatives.

1. POUND SEIZURE

Pound seizure is the practice of taking dogs and cats from animal shelters for use in biomedical research. It began when there was no animal-breeding industry to meet the needs of a growing biomedical research industry. Today, however, there is a large animal-breeding industry; pound seizure is an archaic practice. Pound seizure, moreover, is a dangerous practice because it jeopardizes the effectiveness of community animal-control programs by undermining public confidence in community animal shelters.

A shelter functions as a refuge for homeless animals until they can be reunited with their owners or adopted into good homes. If good homes cannot be found, the community can be assured that the animals it entrusts to the shelter will be humanely euthanized by caring shelter workers. The community's trust in its shelter is broken when the shelter is obligated to release animals to researchers. When this trust is broken, the entire community suffers because of an increased number of abandoned animals, dog bites, and the spread of disease.

In addition, both researchers and potential adopters want the same kinds of dogs and cats — those that are healthy, friendly, and well-behaved. The dogs and cats selected as research subjects are the most likely shelter animals to be adopted. Moreover, animals selected for research do not always have a chance to be adopted before becoming experimental subjects.

It is true that seven to eight million animals die in shelters each year. It is also true that the deaths of these animals are a tragedy for your community. The HSUS wants you to understand, however, that using these animals in biomedical research compounds this tragedy. The HSUS and community shelters are working to improve animal control so that the number of animals euthanized each year will decrease. Without the trust of communities, however, shelters lose important financial support and public assistance. If communities do not participate in animal control, everyone suffers.

Shelter dogs and cats comprise less than one percent of all animals in research, and this percentage is decreasing. Also, because shelter animals have unknown medical backgrounds, genetic endowments, temperaments, and ages, they cannot make good research subjects for most purposes.

Proponents of pound seizure claim that shelter animals are necessary for scientific research because they are inexpensive. This economic analysis is faulty because it considers only purchase prices. It fails to consider hidden costs. These hidden costs include vaccinating, treating, and quarantining newly arrived shelter animals. In additon, there is the cost of replacing animals that die before, during, and after experiments. A University of Oregon study showed that pound animals can in fact be more costly to use than purpose-bred animals, despite their lower initial purchase price.

Eleven states — Connecticut, Delaware, Hawaii, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Pennsylvania, Rhode Island, and Vermont — have recently banned pound seizure. In addition, pound seizure is prohibited in Great Britain, The Netherlands, Denmark, and Sweden. The World Health Organization and The Council of Europe strongly recommend against the use of shelter animals in research.

Of the millions of animals used in biomedical research each year, only 300,000 — less than one percent — come from community animal shelters. Because NIH funds projects that use shelter animals, The HSUS is asking this Committee to help us put an end to this practice.

2. CHIMPANZEES IN RESEARCH

The NIH recently embarked on an ambitious chimpanzee-breeding program to ensure that a steady supply of chimps will be available for biomedical researchers. Unfortunately, the program fails to address serious humane issues.

NIH is funding five chimp-breeding colonies and five projects aimed at enhancing reproduction at these colonies. The HSUS has the following concerns about this NIH program: (1) Chimpanzees have 99 percent of their genetic material in common with human beings. Because chimps are so close to humans on the evolutionary scale, using chimps in research raises certain ethical questions. In addition, alternatives to the use of chimps are not mentioned in this plan, and alternatives have not been treated as a subject worthy of study. (2) No types of experiments are classified as impermissible.

This means that anything the mind can conceive can be submitted for peer approval and performed on a chimpanzee. (3) No provision is made for international coordination of research, an inadequacy that could give rise to redundant research. (4) In its present form, the program does not address the issues of rehabilitation, retirement, or euthanasia. And (5) NIH fails to specify that young animals be kept with their mothers throughout infancy.

Congress rejected this plan in 1986. When congressional appropriations were not forthcoming, however, NIH used 4.5 million dollars from its AIDS special budget to fund the plan. Congress, therefore, is not likely to have any input in a program that could cost taxpayers a minimum of 11 million dollars over the next four years.

As it is, NIH's program is unacceptable to The HSUS. We are prepared to work with NIH on a reformulation of the program but will fight to end it if substantial modifications are not made.

We ask that if NIH comes before you to request additional money for this program that you deny this request until NIH addresses these humane concerns. If NIH does not request additional money but attempts to continue funding this unauthorized program with AIDS money, we ask that you restrict such spending.

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3. ALTERNATE METHODS OF RESEARCH

In P.L. 99-158, Section 4, the 1985 NIH authorization, Congress directed NIH to establish a plan for "...research...into methods of biomedical research and experimentation which do not require the use of animals; which reduce the number of animals used in such research; or which produce less pain and distress in such animals than methods currently in use...." Congress has recognized that these alternate methods of research are not only more humane but could also "provide more accurate research results and reduce the cost of research...."

We applaud this congressional directive, and we applaud NIH's efforts in drafting this plan. NIH, however, did not earmark any money for this program. Instead, it invited interested researchers to submit grant applications through standard channels for NIH research grants. Given this situation, The HSUS is concerned that grant reviewers will not give special attention to these proposals and will only routinely consider them.

If this happens — that is, if NIH does not give particular notice to alternatives proposals — alternatives research will fall through the cracks of the system; no money will be directed toward research and development of alternatives. As a potential remedy, this Committee should consider stipulating that NIH earmark special funding for alternatives research. Your special attention can ensure that NIH's plan for alternatives, the 1985 congressional directive, will be implemented.

The HSUS is grateful for this opportunity to present our views.

Senator BURDICK. This Nation is beset by a horrible disease called AIDS. And one of the witnesses here this morning testified and said they had to have research, and they were using animals from the monkey family but not chimpanzees.

What do you think of that idea?

Dr. STEPHENS. Well, chimpanzees are being used in this research.

Senator BURDICK. Well, this gentleman said they are not using them.

Dr. STEPHENS. They are not using them at his facility. They are using macaques.

Senator BURDICK. That is immaterial. The question is, they use others than chimpanzees. Is that permissible?

Dr. STEPHENS. Well, let me preface my remarks by saying the Humane Society of the United States is not opposed to the reasonable and necessary use of animals in research.

I have been following somewhat the AIDS problem and research on that problem. And it is my impression, and I am a biologist, that the most exciting research on that disease is currently being done in tissue cultures to develop treatments for the disease, and that as far as vaccine development goes, even officials of the NIH—Dr. Anthony Fauci, for example—are now questioning the applicability of the chimpanzee model for human AIDS.

And it is the chimpanzee model that has been held up as the best, albeit a weak model, for human AIDS. So if the chimpanzee model is inadequate, then I do not see how we could invest a lot of money into the monkey model of human AIDS, especially in developing new buildings that will take years to go up when we have the crisis today.

Let me point out, Mr. Chairman, that human testing of potential AIDS vaccines has already begun, and I do not see how pouring money into new facilities is going to affect the problem at hand.

Senator BURDICK. I do not know where you left me. The point is, would you use any type of animal at all in AIDS research?

Dr. STEPHENS. Where it is necessary, perhaps to test if a vaccine is poisonous. But it may not be necessary to see if a vaccine is efficacious, because of the inadequacy of the models.

Senator BURDICK. Thank you very much.

STATEMENT OF ALVIN BLOCK, PRESIDENT, ESA, INC.

Senator BURDICK. Our next witness is Alvin Block, president of ESA, Inc.

Mr. BLOCK. Mr. Chairman and members of the committee:

I am Alvin Block, president of ESA, a biomedical research and instrument manufacturing company located in Bedford, MA.

Today I would like to discuss the small business innovation research program, and its impact on ESA.

ESA has developed a neurochemical analyzer which provides an indication of biochemical activity in the brain and body by measuring patterns of neurochemicals in a number of body fluids such as blood, urine, and cerebrospinal fluid.

These measurements permit the simultaneous qualitative and quantitative analysis of large numbers of the neurochemicals of interest, which is a capability not achievable by any other method.

Neurochemicals are the message carriers between the brain and the rest of the body. They report on the state of health of the body, and in return, carry commands on how they should react.

Various sources have been quoted as saying the brain is the last frontier of medical science. The neurochemical patterns analyzed by the instrument provide correlations to and insights into the mechanism and possible treatment of a number of mental and physical disorders.

These include Alzheimer's, Parkinsons, and Huntington's diseases, depression, nausea, and certain carcinomas and types of heart disease.

Widespread use of this instrument could have a major positive impact on the Government's health care cost containment effots.

ESA has received three phase 1 and one phase 2 SBIR grants. Under these and other research efforts, we have worked with collaborators at Harvard Medical School, Massachusetts General Hospital, McClean Hospital, the Bedford and Brockton VA hospitals in Massachusetts, the University of Lowell and the Wright State University School of Medicine in Ohio.

Although we developed the instrumentation in-house, it required a medical community input to provide insight into the most appropriate areas for research, and to provide biological specimens for analysis.

The ability to apply for and receive SDIR grants, which include a peer review, was, and is, of great value in establishing the credibility of the technology and in encouraging medical researchers to collaborate in application studies.

A joint proposal with the Massachusetts Alzheimers Research Center, with Massachusetts General Hospital, and the Massachusetts Institute of Technology, has been submitted to the National Institute of Aging to correlate neurochemical patterns with Alzheimer's disease.

We would like to thank the Division of Research Resources, National Institutes of Health, for their continued support of our efforts.

Occasionally, plans surface to terminate the SBIR program. We note with pleasure that the Congress has recently extended the authorization for SBIR's to 1993.

I am hopeful that this one story about the successful use of this program will prompt you to more aggressively support this program.

PREPARED STATEMENT

Mr. Chairman, I have some additional material on the Alzheimer proposal that I would like to submit for the record.

Thank you.

Senator CHILES [presiding]. Thank you very much. Your material will be placed in the record.

[The statement follows:]

STATEMENT OF ALVIN V. BLOCK

I am Alvin V. Block, president of ESA, a biomedical research and analytical instrument manufacturing company located in Bedford, MA. Today, I would like to discuss the Small Business Innovation Research [SBIR] Program and its impact on ESA. The SBIR Program has been in existence since 1983. Its stated goals are to: Stimulate technological innovation; use small business to meet Federal research and development needs; increase private sector commercialization of innovations derived from Federal research and development; and foster and encourage participation by minority and disadvantaged persons in technological innovation.

I would like to tell you of ESA's success with this program.

ESA has developed a neurochemical analyzer which provides an indication of biochemical activity in the brain and the body by measuring patterns of neurochemicals in a number of body fluide such as blood, urine, and cerebrospinal fluid. Neurochemicals are the message carriers between the brain and the rest of the body, reporting on the state of health of the body and, in return, carry commands on how it should react. Various sources have been quoted as saying "the brain is the last frontier of medical science." There has been an important need identified by many biomedical researchers to improve on methods of detecting, identifying, and measuring the many chemical substances in the brain which determine the state of health and behavior. The neurochemical patterns analyzed by the instrument provide correlations to, and insights into, the mechanism and possible treatment of a number of mental and physical disorders. These include Alzheimer's, Parkinson's, and Huntington's diseases, depression, emesis (nausea), and certain carcinomas and types of heart disease. These disorders presently cost society between $100 and $200 billion per year. Widespread use of this instrument could have a major, positive impact on the Government's health care cost-containment efforts.

ESA has received three phase 1 and one phase 2 SBIR grants. Under these and other research efforts, we have worked with collaborators at Harvard Medical School, Massachusetts General Hospital, Bedford and Brockton VA Hospitals in Massachusetts, University of Lowell, and Wright State University School of Medicine in Ohio.

ESA is a small, privately held company with limited resources. From 1983 to the present time, it has committed over $2 million of its own funds to develop this instrument. This has seriously strained our corporate resources. The $650,000 that we have received from SBIR grants has provided additional support to demonstrate the applicability of this technology to a number of medical research problem areas.

Although we developed the instrumentation in-house, it required a medical community input to provide insight into the most appropriate areas for research and to provide biological specimens for analysis. The ability to apply for and receive SDIR grants (which include a peer review) was and is of great value in establishing the credibility of the technology, and encouraging medical researchers to collaborate in application studies. We also received public forum for evaluating the results of our studies. The SBIR Program has fostered much closer ties for ESA with the highest levels of medical technology. Yet, more research is necessary to achieve the goals of better understanding and treatment of disorders which can be addressed with this instrumentation.

A joint proposal with the Mass Alzheimer's Disease Research Center, Massachusetts General Hospital, and Massachusetts Institute of Technology has been submitted to the National Institute of Aging to correlate neurochemical patterns with Alzheimer's disease. The Massachusetts Alzheimer's Center has access to several hundred Alzhemier's, Huntington's Parkinson's, and multiple infarct patients as well as a number of other rate degenerative disorders. Patient histories, familial relationships, and clinical data are well documented.

The analysis of samples on ESA's neurochemical analyzer will be carried out at Massachusetts General Hospital and MIT. ESA will provide an overall quality assurance program and participate in the management of the data base.

The expected data will link time trajectories of several hundred individuals with several hundred relevant neurochemical parameters.

The data base as an entity will serve as a resource and starting point for a number of efforts in Alzheimer's disease research, such as: Development of neurochemical diagnostic protocols for Alzheimer's disease and other degenerative disorders; development or specifications of new pharmacological approaches; testing of existing pharmaceuticals; and study of mechanistic similarities/differences of degenerative disorders.

We would like to thank the Division of Research Resources, NIH, for their continued support of our efforts.

Occasionally, plans surface to terminate the SBIR program. We note, with pleasure, that the Congress has recently extended the authorization for SBIR's to 1993. I am hopeful that this one story about the successful use of this program will prompt you to more aggressively support this program.

DEVELOPMENT OF A NEUROCHEMICAL DATA BASE FOR ALZHEIMER'S DISEASE AND RELATED DEGENERATIVE DISORDERS

PREPROPOSAL OUTLINE

The detailed understanding of the neurochemical correlates of Alzheimer's disease and other degenerative disorders will provide one major route to their understanding and control. An extensive multiparameter neurochemical data base is an important element in providing such understanding. In order to be effective a data base must meet three major criteria. (1) It must have a highly documented degree of analytical certainty and reliability. (2) It must encompass a large number of neurotransmitters, precursors, metabolites, and cofactors of known or suspected relevance. (3) It must have a patient or sample population with a highly documented clinical history over a period from onset to death.

The resources and interdisciplinary capabilities to provide a degenerative neurochemical data base resource exist at the Massachusetts General Hospital/Massachusetts Institute of Technology Alzheimer's Disease Research Center, and Departments of Neurology, and at ESA, Inc. The Massachusetts General Hospital/MIT Alzheimer's Disease Reserach Center and Neurology Research Department have access to several hundred Alzheimer's, Huntington's, Parkinson's, and multiple infarct patients as well as a number of other rare degenerative disorders. Sample types available include postmortem brain tissue, ventricular CSF, lumbar CSF, and plasma. Patient histories, familial relationships, and clinical data are highly documented. Sophisticated amino acid and immunoassay procedures have been developed at Massachusetts General Hospital.

With Division of Research Resources support, ESA, Inc., has developed a multisensor neurochemical analysis technology capable of highly cost-effective analysis of the majority of relevant neurochemicals. Several hundred components can be isolated and quantified at femtogram levels in a single sample with a high degree of qualitative certainty. ESA has on staff the senior programmer from the team responsible for the development of the Data General ORACLE data base management system and the MGMIS and ORALISP communication systems.

The collaborative application of these capabilities will result in a uniquely qualified data base resource for Alzheimer's disease and related disorders. The generation of the proposed data base is broadly separated into two phases of effort.

In the first 6 to 12 month phase, ESA will document the analytical methods and quality assurance protocols necessary to provide accurate analytical information (for example, all aspects of sample acquisition, storage, preparation, and analysis) and train MGH/MIT personnel on the multisensor equipment. ESA, Massachusetts General Hospital, and MIT will collaborate on the specifics of the data base design (for example, storage, recall, correlation, data categories, et cetera).

In the second phase, ESA will provide Massachusetts General Hospital and MIT with complete multisensor analytical capabilities with turnkey methods. The analysis of samples will be carried out at Massachusetts General Hospital and MIT. ESA will provide an overall quality assurance program and participate in the management of the data base.

The expected structure of the data will link time trajectories of several hundred individuals within clinically documented disorder categories with several hundred relevant neurochemical parameters. The data base as an entity will serve as a resource and starting point for a number of efforts in Alzheimer's disease research, such as the following: Development of neurochemical diagnostic protocols for Alzheimer's and other degenerative disorders; development or specification of new pharmacological approaches; testing of existing pharmaceuticals; and study of machanistic similarities/differences of degenerative disorders.

STATEMENT OF DR. VIRGINIA MILLONIG, NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES & PRACTITIONERS

Senator CHILES. Now we will hear from Virginia Millonig with the National Association of Pediatric Nurses.

Dr. MILLONIG. Mr. Chairman and members of the committee, thank you for the opportunity to speak before you today.

I am Dr. Virginia Millonig, and I am speaking on behalf of the National Association of Pediatric Nurse Associates & Practitioners, in support of full funding for the Nurse Amendments Act of 1985 of $56.60 million for fiscal year 1988, and $27 million for the National Center for Nursing Research.

Because of the dramatic and the drastic shortage of nurses, which is affecting this country nationwide today, and the decreased enrollment in the schools of nursing, the Federal Government's support of both of these bills is without question.

The Nurse Education Amendments of 1985 provide for preparation of nurse specialists, administrators and educators, whereas the Center for Research is devoted to improved quality of care, improved delivery of services, and subsequently, decreased costs.

The Federal Government cannot afford to offer only limited support of these bills, since the delivery of health care in the country is dependent upon an adequate supply of nurses, and cannot survive without nurses.

Mr. Chairman, and members of the committee, you and I cannot survive without nurses. We implore you and members of the committee to please consider these recommendations as outlined.

I thank you for the opportunity to speak before you today, and would be happy to entertain any questions.

Senator CHILES. Thank you very much.

PREPARED STATEMENT

I have seen some of the figures and statistics on what those demands are going to be, and what those needs are going to be.

And I think we are going to need to continue to help in that area.

[The statement follows:]

STATEMENT OF DR. VIRGINIA MILLONIG

Mr. Chairman and Members of the committee, thank you for allowing me the opportunity to speak before you today. I am Dr. Virginia Millonig, a pediatric nurse practitioner who has been practicing and teaching for the past 12 years. I have served on the Executive Board of NAPNAP for the past four years. Today I am speaking on behalf of the National Association of Pediatric Nurse Associates and Practitioners in support of full funding for nursing education and an appropriation of $27 million for the National Center for Nursing Research.

In testimony before this committee last year, we emphasized the changing role of nurses in the health community. That role, and the role of the nurse practitioner, has continued to evolve. Today, nurse practitioners are recognized for their expertise in promoting wellness, in their ability to provide cost - effective care in an increasingly costly atmosphere, and in their teaching methods for health education, counseling and therapy.

We continue to maintain a high quality of care for our patients. In answer to congressional request, the Office of Technology Assessment issued a report in December of 1986, discussing the role of the nurse practitioner and other specialty groups in the health community. One chapter of the report was devoted to the quality of care issue. If I may, I would like to read to the Committee a quote from that report:

> Reviews of comparison studies...and individual studies comparing NPs and physicians find that the quality of care provided by NPs functioning within their areas of training and expertise tends to be as good as or better than care provided by physicians.

The nurse practitioners are not alone. In case after case the care provided by nurses is professional, expert and commendable. We have proven to be a valuable part of the health care team.

Our concern in health reaches beyond the boundaries of the clinical setting. We work hard for initiatives supporting wellness and safe health care activities.

For example, in the past year the National Association of Pediatric Nurse Associates and Practitioners has been in the forefront promoting child car seats. We support and have pushed legislation mandating regulation child car seats for every vehicle driving with a young child. An approved, regulation car seat saves millions of small lives every year. In our efforts to educate parents on the value of child car seats, we have developed a public service announcement appearing on television nationwide explaining the importance of a restrictive seat.

In coordination with the Proctor and Gamble company, we have produced an educational campaign featuring a pediatric nurse practitioner using ultra pampers. The spot emphasizes wellness of child and an effort to educate the public about the role of PNP's.

The National Association of Pediatric Nurse Associates and Practitioners is only one segment of a changing nursing community. The community is increasingly becoming more specialized -- addressing specific areas of concern including geriatrics, midwifery, anesthesiology, drug and alcohol and so forth. We welcome the increasing number of specialties. We believe it increases the effectiveness and quality of our care and in a constantly changing environment, it provides for a specific expertise as opposed to a general knowledge in all areas.

I would like to focus your attention today on the Nurses Education Amendments of 1985 and the National Center for Nursing Research (NCNR) at the National Institutes of Health (NIH). But, neither of these topics can begin to be addressed without commenting on another growing, and frightening, trend that is emerging -- that of a drastic shortage of practicing nurses and a decrease in the number of students enrolling in our nation's nursing programs.

The Nursing Shortage:

The Washington Post recently devoted an editorial to the problem facing each of the 35 hospitals in the Washington area. It is estimated that today there is a shortage of approximately 1,000 nurses in the area -- resulting in an average vacancy rate of about 15 percent.

This problem is not isolated for the District. It is being felt in every health care facility across the United States. In some areas, recruiting efforts are being used to lure nurses from other countries in an effort to quell the shortage. While many of the reasons for this dramatic shortage are only now under scrutiny, it can be attributed in part to the decreased enrollment of students in schools of nursing. The Nurse Education Amendments of 1985 were implemented to provide funds to prepare nursing specialists, nursing administrators and nurse educators. It could be argued that these funds are needed more today, than they were when initiated in 1985. It is of upmost importance that the Federal Government demonstrate its commitment and concern in continuing the education of nurses. A continued appropriation for the Nurse Education Amendments of 1985 is, without question, a necessity.

The National Association of Pediatric Nurse Associates and Practitioners supports the Nurses Coalition for Legislative Action recommendation for an appropriation of $56.60 million in FY '88 for the Nurse Education Amendments of 1985.

The National Center for Nursing Research (NCNR)

The National Center for Nursing Research (NCNR) was established at the National Institutes of Health (NIH) just one year ago this month. In its first year, NCNR has moved quickly in carving a niche for nursing research. The center has worked hard in accomplishing their goals in improving techniques and developing innovative nursing services.

In this regard, the NCNR awarded 110 research awards and 165 training awards. Additional proposals are under consideration. The NCNR has been divided into four branches, each responsible for a specific area of research. These four branches are: the Health Promotion and Disease Prevention Branch, the Acute and Chronic Illness Branch, the Nursing Systems and Special Programs and finally the Research Development and Review Branch.

To continue in this strong form the National Association of Nurse Associates and Practitioners recommends an appropriation of $27 million in FY 1988 for the National Center for Nursing Research. This appropriation level is $8 million above the FY 87 budget. This increase will insure that the NCNR can keep the momentum started in its' first year. Keep the momentum in developing research for wellness. Keep the momentum in teaching and training nurse scientists. Keep the momentum in developing the highest caliber of nursing techniques and nurses that is possible.

Mr. Chairman, Members of the committee, my thanks to you for giving me the opportunity to speak before you today. I hope you will consider the recommendations as outlined. On behalf of the National Association of Pediatric Nurse Associates and Practitioners, I would be happy to answer any further questions you may have.

STATEMENT OF ELVA BUSCH, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Senator CHILES. Our next witness will be Elva Busch with the American Association of Nurse Anesthesiologists.

Ms. BUSCH. That is nurse anesthetist.

Good morning, Mr. Chairman. It is a pleasure to speak before the committee today. I am Elva Busch. I am a member of the board of directors of the Amerian Association of Nurse Anesthetists for whom I speak today.

I bring requests about the nurse education amendments of 1985, and the National Center for Nursing Research.

There are presently about 23,000 certified registered nurse anesthetists [CRNA's]. They provide 70 percent of anesthesia services in the rural areas, and over 50 percent across the Nation.

Documentation shows that their delivery of care and services is of high quality. Nurse anesthetists are an integral part of the health care team.

Everyone in this country is becoming increasingly aware of a severe nursing shortage. According to the American Hospital Association, nursing vacancies in hospitals have more than doubled.

The most severe shortages are being felt in critical care areas, and this is of particular concern to us, since this is the pool we draw upon to enter nurse anesthesia.

Our own data demonstrates a significant increase in the need for CRNA's across the country. We already cannot fill the need.

Meanwhile, the number of students in programs of nurse anesthesia has declined, and there are fewer programs as well. Funding is extremely important to assure that we will have adequate numbers in the future to care for the public.

If the number of CRNA's continues to decline, health care costs will certainly rise. Positions may be filled by another provider, the anesthesiologist, whose costs are more than triple, considering the costs associated with education, training and the fee charges that are associated with physicians.

So as the nursing shortages increase, costs, we predict, will go up.

One solution to the problem is ongoing and increasing education benefits. The nurse education amendments of 1985 were adopted to support higher nursing education. The amendments provide funds for traineeships for registered nurses wishing to become nurse anesthetists.

The programs are 2 years in length, in either a certificate or a master's level framework. This is after preparation as a registered nurse, and experience in critical care nursing.

Funds are also provided for advanced nurse training, nurse practitioners, nurse midwifery, special projects, and faculty fellowships.

The American Association of Nurse Anesthetists recommends a continued and increased appropriation for the nurse education amendments of 1985.

We support the nurses coalition for legislative actions—recommendation for an appropriation of $56.6 million in fiscal year 1988, with a particular request for $800,000 for nurse anesthesia traineeships.

The National Center for Nursing Research was created by Congress last year. This new institute, at the National Institutes of Health, granted almost 300 awards for research and nursing in its first year.

By conducting nursing research in many areas, researchers are discovering new techniques in an effort to provide better and more cost effective patient care.

The Center is a worthwhile and needed addition to the medical community. It must continue.

The American Association of Nurse Anesthetists recommends an appropriation of $27 million in fiscal year 1988 for the National Center for Nursing Research.

We ask this committee, Chairman Chiles, for a firm commitment. The nursing community is facing a critical time. We must support all levels of nursing to correct the nursing shortage which threatens to change the entire health community.

PREPARED STATEMENT

And I thank you for this opportunity today. I would like to submit some additional brochures in support of my testimony today.

Senator CHILES. Thank you, ma'am. We will see that your brochures are made a part of the record.

Thank you for your attendance here today.

[The statement follows:]

STATEMENT OF ELVA BUSCH

Mr. Chairman and members of committee, it is a sincere pleasure to speak before you today and I thank you for the opportunity. I am Elva Busch, and have been a practicing nurse anesthetist for the past fifteen years. I was an originator and former director of the nurse anesthesia program in Connecticut. As an active board member I am here today speaking on behalf of the American Association of Nurse Anesthetists.

I would like to focus my comments on three items: the Nurse Education Amendments of 1985, the National Center for Nursing Research (NCNR) at the National Institutes of Health (NIH), and the present, and quite critical, nursing shortage.

The nursing shortage is perhaps the most pressing item before us today. The consequences of the shortage will have a long range impact on both the Nurse Education Amendments and the National Center for Nursing Research -- not to mention the Defense Department, the Veterans Administration, the National Institutes of Health and every public and private hospital and clinic in the United States.

The statistics are now being gathered while nurses are being asked to work longer shifts and care for more patients. The nurse vacancies in hospitals have more than doubled. According to the American Hospital Association data, the vacancy rate for nurses in U.S. hospitals rose from 6.3 percent in 1985 to 13.6 percent in 1986. The shortages are especially severe in critical care areas, and this is the pool of nurses from which we select those who enter the field of nurse anesthesia.

More importantly, our own data shows a significant increase in the need for CRNAs all over the country, as reflected by the increased number of job vacancies for CRNAs in areas all over the country.

At the same time, since 1982, the number of students enrolled in accredited nurse anesthesia programs has declined.

Partly as a result, 55 nurse anesthesia education programs will have closed by 1988.

There are at present about 20,000 actively practicing CRNAs. Seventy percent of the services of CRNAs are delivered in rural areas. Without question, nurse anesthetists have become an integral part of the complete health care team. But the number of CRNAs continues to decline. If the number of CRNAs continues to decline, the health care costs are certain to rise as our positions will be filled by anesthesiologists whose costs are more than triple -- if one considers the costs of education, training and fee charges associated with physicians.

While answers to the nursing shortage are only now being scrutinized, certainly one solution lies in continuing and increasing the education benefits. The Nurse Education Amendments of 1985 were adopted to support higher education in nursing. The Amendments provide funds to institutions nationwide for traineeships for registered nurses who wish to become nurse anesthetists. This is a two-year certification or master's degree program -- a program which can only be entered after becoming a registered nurse and acquiring experience as a critical care nurse. In addition, funds are provided for, among other activities, advanced nurse training, nurse practitioners, nurse midwifery, special projects, and faculty fellowships within the nursing education program.

The American Association of Nurse Anesthetists recommends a continued and increased appropriation for these activities authorized by the Nurse Education Amendments of 1985. We support the Nurses Coalition for Legislative Action recommendation for an appropriation of $56.60 million in FY 1988, with particular request for $800,000 for nurse anesthetist traineeships.

THE NATIONAL CENTER FOR NURSING RESEARCH

In April of 1986, Congress granted approval for a new Institute at the National Institutes of Health -- the National

Center for Nursing Research (NCNR). In that one year period, the NCNR has granted almost 300 awards for research and training.

Since its inception, the goal of the NCNR has been to discover new techniques and refine the old techniques in an effort to provide better and more cost-effective care for the patient. The NCNR conducts research for all patients, including the elderly, the handicapped, the young, and AIDS victims. Although still a young institution, the NCNR has been recognized as a worthwhile and needed addition to the medical care research community. The work of the Institute should be allowed to continue and grow in the future.

We hope that the Committee, and the Congress, will continue to support the National Center for Nursing Research as they did in its first year. Contrary to the Adminstration's recommendation for level funding, the American Association of Nurse Anesthetists recommends an appropriation level of $27 million in FY 1988 for the National Center for Nursing Research.

A continued and firm commitment from Congress and you, Chairman Natcher, is badly needed. The nursing community is facing a critical time period. We must revitalize the nursing corps and support from all levels is a first step in slowing the nursing shortage that threatens to change the entire health care community.

Thank you very much for allowing me the opportunity to speak on behalf of the American Association of Nurse Anesthetists. We commend the Committee's work. I will be happy to answer any further questions you might have.

STATEMENT OF LEON JACOBS, PH.D., CHAIRMAN OF THE BOARD, GORGAS MEMORIAL INSTITUTE

Senator CHILES. Now we will hear from Mr. Leon Jacobs, the Chairman of the Board of Directors of the Gorgas Memorial Institute of Tropical and Preventative Medicine.

Dr. JACOBS. Thank you, Mr. Chairman.

I am here to discuss the U.S. contribution to the Gorgas Memorial Institute. This contribution is channelled, for administrative purposes, through the Fogarty International Center of the National Institutes of Health.

You have a prepared statement, but I would like to reiterate some emphases in that statement, and to tell you of current activities and problems.

Senator CHILES. Your statement in full will be put in the record.

Dr. JACOBS. Yes; I understand. Well, this is not a reiteration of the statement. This is just some emphases.

One of the functions that the Gorgas Memorial Laboratory performs in Panama is the surveillance of various diseases like yellow fever.

Yellow fever survives as a jungle disease which occasionally erupts and spreads toward the canal area.

Gorgas Laboratory aids in advising authorities on the verification of the disease spread, and the need for spraying or other control measures.

We have done the same thing for encephalitis, St. Louis encephalitis and Venezuelan and equine encephalitis, and also for influenza.

We also monitor the occurrence of drug resistant strains of malaria.

These are things we do in addition to our research effort. And these things complement and assist U.S. Government agencies, World Health Organization, and others, in the monitoring and control of various vector-borne diseases.

Research is our main effort, and we do a wide spectrum of research, from arbovirology, that is, the study of viruses which are spread by flying insects mostly, and some other types of arthropods, and parisitology, skin diseases of just tremendous mutilating capability, leishmaniasis, for instance.

I was very sympathetic, therefore, in hearing the comments of the people who appeared before us earlier on the dermotological problems that people have.

We have similar diseases in the tropics. Some of them are infectious and cause an enormous amount of mutilation to human beings.

We do work on the shaugus disease, which is a very, very important trypanozome disease of the tropics; on hookworms; and other organisms, which are the domain of the paristologists.

We also work on entomological problems, and on ecology and epidemiology. Our epidemiological work extends beyond the ordinary concept of tropical diseases to diseases which occur in large incidence in the tropics.

We do all these things under constraints of our very short budget. Our authorization has not increased consummate with the increased inflation, and we have a real problem in maintaining our buildings, and in maintaining many of our programs, our core programs such as the surveillance ones that I have mentioned.

I see that the light has come on, and I have run out of time. But I respectfully request that the appropriation for the Gorgas Memorial Institute and Laboratory be at the complete authorization level of $2 million, which is around $64,000 less than what is in the appropriation request of the NIH.

PREPARED STATEMENT

Thank you very much.

Senator CHILES. Thank you very much.

[The statement follows:]

STATEMENT OF LEON JACOBS

Thank you very much for this opportunity to present the justification for the annual contribution of the U.S. to the Gorgas Memorial Institute.

I am Leon Jacobs, Chairman of the Board of Directors of the Gorgas Memorial Institute of Tropical and Preventive Medicine, Incorporated (GMI). My curriculum vitae is attached to my written statement.

As you know, the Congress of the United States has, since 1928, provided an annual contribution to the Gorgas Memorial Institute for the operation and maintenance of the Gorgas Memorial Laboratory in Panama. This contribution has been channeled, administratively, through the Fogarty International Center of NIH since 1971. Prior to that year, the National Institute of Allergy and Infectious Diseases was the agency administering the contribution, and before that arrangement was made in 1958, the Department of State channeled the funds to GMI.

It is not so well known that the government of Panama also makes a contribution to GML. This contribution is in the form of funds, $10,000 annually, which represents, in proportion to the population of Panama and its gross national product, a significant amount relative to that provided by the United States. In addition, Panama contributes by the provision of physicians and technical personnel, paid by the Ministry of Health and assigned to GML for specific projects. The arrangement is helpful to the Ministry of Health in that it provides research training and experience to young physicians, and to GML in providing extra pairs of skilled hands for some of its projects. One additional way Panama assists GML is by exempting it from customs duties and certain other taxes; this represents a considerable saving to the Laboratory.

Let us return for a moment to the U.S. contribution. It is clear that the Congress entitled the sums of money designated for GMI under the original authorization act, P.L. 70-350, as a contribution, not to be intermingled in the appropriations of the govermental agency thru which the funds were to be channeled. The funding of GMI/GML is under quite different legislative authority from those laws providing authorization for the appropriations of the NIH or any of its components. The failure to make this distinction in the recent past has resulted in some critical times for us, as in 1983 when NIH decided to eliminate some center grants and include GMI among "grantees" that were to be deleted from the appropriation request. It was only by the discernment and wisdom of the appropriations subcommittees of the Congress that GMI was rescued from otherwise certain death. You are aware of the studies conducted in 1983 by the Office of Technology Assessment and the General Accounting Office that were the basis for the rescue. While the reports of these agencies were not uniformly commendatory of the activities of GMI and the Laboratory in Panama, on the whole they indicate that GMI/GMI were worth continuing and were doing good and important work. In consonance with new attitudes concerning the role of the public and private sectors of our society, we were urged to seek private donations to sustain our work. We have tried to do so, and we are continuing to explore additional methods of fund-raising and additional sources, but as yet we have not been successful. It is a painful and slow process and we have to struggle against a general lack of interest concerning exotic diseases. Moreover, some of our activities are far from glamorous although they are necessary, such as surveillance of the types of influenza virus observed in the canal region, because it is easy for new types to arrive there; and such as monitoring the occurrence of yellow fever and dengue, and the viral encephalitides. In addition to our own research, these service activities and others enhance the ability of U.S. government agencies and U.S. universities to do their own control work and their own research, and there is general profit from this type of cooperation.

We have also extended the range of our interests to diseases that are not "tropical" in the conventional sense. We study diseases of wider distribution when they appear to present different or special problems in our arena. For example, the occurrence of a high rate of leukemia and lymphoma, and of cervical carcinoma, in some provinces of Panama and also elsewhere in Central and South America, has led us into contract- and grant-supported studies on human T-cell leukemia virus type I (the AIDS virus, now called HIV, is type III) and of human papilloma virus, as to their epidemiological relation to the diseases mentioned. In Panama and other countries, one of the most important causes of morbidity and mortality among infants and young children is acute respiratory disease, and although we do not have funding for specific studies on these conditions, we do spend time and some core funding to gather basic data that can serve to support applications for special support for the attack on this problem.

We have an active program in arbovirology. Grant-supported research is being conducted on the transmission of an arbovirus, the Gamboa virus, through the different stages of the mosquito vector, providing information on the possibility that the virus can be maintained in nature without the requirement of replication in a vertebrate host. This has been very successful thus far, and we currently have an application in process for a renewal of the grant, to allow continued research in this very interesting model of human arboviruses and their methods of maintaining themselves in nature.

Our principal parasitologist has been recruited to become the Dean of Graduate and Research Studies at the University of Panama, and we are in the process of recruiting a new scientist in this field. In the meantime, we still have some work in parasitology going on, such as studies on the effects of drugs on hookworms and on leishmania parasites. These studies are supported with funds from pharmaceutical firms.

We are doing all of these things under serious financial straits. While the authorization for the U.S. contribution has increased over the years, it has really not kept pace with inflation. We made a decision in 1974 to take over continuing activities of the Middle America Research Unit of the National Institute of Allergy and Infectious Diseases (NIAID) that had been situated for some years in the then Canal Zone. Our decision was reaction to a request from NIAID that we consider this enhanced responsibility. What happened when we did this was that we assumed responsibility also for personnel whom we later had to terminate at great cost. The result has been more than a decade of financial distress. We have continued to examine all our programs and are retaining only those that show good prospects for further contributions to knowledge or that are important in regard to our preventive medicine role. We have projects and expertise in regard to disease problems that are of increasing concern to our own military. In addition to providing facilities and instruction needed in the U.S. Navy tropical medicine course given at GML, we are active in research and field observations on these important problems.

I wish to quote a few lines from the OTA report of 1983 which I believe are just as valid today as the day they were written:

"In summary, OTA concludes that the positive consequences of U.S. support of Gorgas greatly outweigh the amount of funds involved. Defunding now, followed by an appreciation of the loss later and a subsequent attempt to reinstate such a large research capability, may result in much larger required investments, an inability to recreate successful conditions for quality research, or both."

In addition to the considerations just mentioned, it is important to point out that the Gorgas Memorial Laboratory has an excellent reputation in the domestic and foreign community, and it stands as a symbol of the ability of U.S. scientists to contribute to the well being of a region neighboring this continent. Indeed, it is the major symbol of U.S. expertise in the field of biomedical research in the entire region. We are well worth your investment, and we hope to convince you in the future to invest more.

We request restoration of the entire $2 million contribution authorized by P.L.70-350 as amended.

Thank you very much for hearing this statement.

CURRICULUM VITAE

Name: Leon Jacobs

Address and Telephone Number:

Home: 3705 Morrison Street, N.W.
Washington, D.C. 20015

Phone: 202/966-2674

Date and Place of Birth:

March 26, 1915
Brooklyn, New York

Educational Background:

Boys High School Brooklyn, New York		1927-1931
Brooklyn College Brooklyn, New York	B.A.	1931-1935
George Washington University Washington, D.C.	M.A.	1936-1938
George Washington University Washington, D.C.	Ph.D.	1939-1943 1946-1947

Tissue Culture Course, Mary Imogene Bassett Hospital, Cooperstown, New York	7/49-9/49
Course in Virology, U.S. Department of Agriculture Graduate School, Washington, D.C.	1949
Course in Ophthalmic Pathology, Armed Forces Institute of Pathology, Washington, D.C.	2/9-13/53
Course in Pathology, U.S. Department of Agriculture Graduate School, Washington, D.C.	1953
Course in Veterinary Pathology, Armed Forces Institute of Pathology, Washington, D.C.	1959

Professional Experience:

Junior Nematologist to Protozoologist, Division of Zoology, NIH	1937-1943
United States Army	1943-1946
Protozoologist to Scientist Director, NIAID, NIH	1946-1956
Head, Section of Protozoal Diseases, Laboratory of Tropical Diseases, NIAID, NIH	1956-1959
Chief, Laboratory of Parasitic Diseases, NIAID, NIH	1959-1964
Acting Scientific Director, NIAID, NIH	1964-1965
Scientific Director, DBS, NIH	1966-1967
Deputy Assistant Secretary for Science, DHEW	1967-1969
Assistant Director for Collaborative Research, NIH	1969-1972
Associate Director for Collaborative Research, NIH	1972-1978
Director, Fogarty International Center, NIH	1978-1979
Visiting Prof. of Microbiology, University of Arizona Medical School	1979-1981
Visiting Prof. of Microbiology, University of So. Florida Medical School	1980-1982
Scientific Director, National Society for Medical Research, Washington, D.C.	1981-1982
Scientific Consultant, National Society for Medical Research, Washington, D.C.	1983- 1985

Membership in Scientific Societies:

American Society of Tropical Medicine and Hygiene	
Editor, *Tropical Medicine News*	1952-1955
Representative to National Research Council	1957-1961
Council	1964-1968
Vice President	1970
American Society of Parasitologists	
Editor, *Journal of Parasitology*	1955-1958
Chairman, Committee on Business Operations	1959-1960
Council	1963-1966
President	1978
American Association of Immunologists	1956-1980
Helminthological Society of Washington, President	1950
Tropical Medicine Society of Washington, President	1971
Society of Protozoologists	1955-1980
American Association for the Advancement of Science	
Sigma Xi	
New York Academy of Sciences	

Research Interests:

Cultivation, epidemiology, and pathogenicity of parasitic protozoa; immunology and serology of protozoan and helminthic infections. Particularly interested in toxoplasmosis (life cycle and epidemiology, immunity, diagnostic procedures, ocular and other clinical manifestations and serology.)

Professional Publications:

Bibliography attached.

Other Activities:

Lectures at Johns Hopkins University School of Hygiene and Public Health	1956-1986
Lectures at Georgetown University Medical School	1965-1968
Lectures and laboratory teaching of parasitology at Western Reserve University Medical School	1954-1958
Representative of the American Society of Tropical Medicine and Hygiene to the National Research Council	1957-1961
Consultant, Committee on Uveitis, American Academy of Ophthalmology and Otolaryngology	1957-1958
Chairman, Committee on Cooperative Publication, Conference of Biological Editors	1958-1960
Director and member of Executive Committee, Gorgas Memorial Institute	1969-1979
Chairman, Toxoplasmosis Sessions, 7th International Congresses on Tropical Medicine and Malaria	1963
Member, Executive Committee, Commissioned Officers Association of the U.S. Public Health Service	6/65
Member, WHO Expert Panel on Parasitic Diseases	1956-1976
Chairman, Panel on Parasitic Diseases, U.S.-Japan Cooperative Medical Science Program	1965-1970
Member, Microbiology Subcommittee, Safe Drinking Water Committee, National Academy of Sciences	1976-1977
Chairman, Subcommittee on Research, U.S-Egypt Joint Health Working Group	1977-1979
Member, Board of Directors, Gorgas Memorial Institute of Tropical and Preventive Medicine, Incorporated	1969-
President and Chairman of the Board, Gorgas Memorial Institute of Tropical and Preventive Medicine, Incorporated	1983-85
Chairman of the Board, Gorgas Memorial Institute of Tropical and Preventive Medicine, Incorporated	1985-
Adjunct Professor of Preventive Medicine, USUHS	1985-

Honors and Awards:

Army Commendation Ribbon	1945
Past President, Helminthological Society of Washington	
Biological Sciences Award of the Washington Academy of Sciences	1954

Arthur S. Flemming Award of the Junior Chamber of Commerce	1954
Brooklyn College Distinguished Alumnus Award	1955
Barnett Cohen Award, Maryland Society of Bacteriologists	1956
Fulbright Research Scholarship	1960-1961
Guggenheim Fellowship	1960-1961
Council, American Society of Parasitologists	1963-1966
Henry Baldwin Ward Medal of the American Society of Parasitologists	1963
George Washington University Alumni Achievement Award	1967
Distinguished Service Medal, USPHS	1966
Superior Service Award, DHEW	1968
Vice President, American Society of Tropical Medicine & Hygiene	1970
President, American Society of Parasitologists	1978

STATEMENT OF SCOTT R. SWIRLING, EXECUTIVE DIRECTOR, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION

Senator CHILES. Now we will hear from Scott Swirling, the executive director of the National Family Planning and Reproductive Health Association.

Mr. SWIRLING. Thank you, Mr. Chairman.

I am Scott Swirling, executive director of the National Family Planning and Reproductive Health Association.

I want to thank you and the subcommittee for the opportunity to address the issue of continued funding for programs under title X of the Public Health Service Act, population research and voluntary family planning programs.

The National Family Planning Association, NFRA, is a nonprofit membership organization in Washington established to improve and expand the delivery of voluntary family planning and reproductive health services throughout the United States.

It is the only organization representing the entire family planning community, from consumers to State and county and local health departments; from hospital based clinics, to affiliates of the Planned Parenthood Federation of America; from umbrella funding councils, to independent, free standing family planning clinics and individual health care professionals.

NFRA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

Title X is the primary source of Federal funding for subsidized family planning services in this country. Since its inception in 1970, the national family planning program has enjoyed broad bipartisan support in Congress and in this committee.

I urge you and your colleagues to sustain that longstanding commitment to quality reproductive health care for all by appropriating $160.36 million for the title X program in fiscal year 1988.

Title X is a medical program serving poor Americans, but it also authorizes contraceptive research and research and development, and research in the reproductive and behavior sciences.

The development of improved methods of contraception could help reduce the number of unintended pregnancies in this country, which accounted for more than 50 percent of all pregnancies last year.

Therefore, NFRA requests that Congress grant a special additional appropriation of $10 million each year for the next 4 years to focus on improving contraceptive technology.

In this year of budgetary austerity, an adequate Federal investment in family planning is more valuable than ever before. Title X is a medical program that serves the poor and the medically indigent. Title X clinics are the entry point for millions of low income women and adolescents into the Nation's health care system.

Hundreds of thousands of unintended pregnancies, many among teenagers, are averted each year as a direct result of clinics receiving title X funds.

Family planning agencies are in the forefront of dealing with AIDS in the local communities. Federal dollars invested in title X more than pay for themselves in savings to public health care and social service costs in the next year alone.

And finally, despite allegations made by the Reagan administration and others, title X funds have never been used to subsidize abortion procedures.

Yet, under the guise of opposing abortion, opponents of family planning have sought to undermine the single most effective Federal program for reducing the need for abortion, title X.

Mr. Chairman, in your other role as chairman of the Budget Committee, we do want to thank you for your efforts to disapprove the 90–10 cut for family planning services under Medicaid, match for states, to 50–50 that the Reagan administration has proposed.

My understanding is that the 90–10 match is still in there, and that you had expressed personal concern and interest in that.

And thank you very much for allowing me to testify.

PREPARED STATEMENT

Senator CHILES. Thank you very much for your testimony. We are delighted to have you here.

[The statement follows:]

STATEMENT OF SCOTT R. SWIRLING

RECOMMENDATIONS OF THE NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION FOR FISCAL YEAR 1988 APPROPRIATIONS FOR THE TITLE X (PHS ACT) FAMILY PLANNING PROGRAM

1. Reject administration efforts to place federal support for family planning services into a block grant and reauthorize Title X for three years.
2. Appropriate $160,360,000 for programs under Title X: $156,200,000 for service program grants and contracts; $3,600,000 for training program grants and contracts; and $560,000 for the development and testing of informational and educational materials and programs. These figures are equal to the Fiscal Year 1988 authorization levels approved on December 11, 1985 by the Senate Committee on Labor and Human Resources in S. 881, the reauthorization legislation for Title X.
3. Condemn the inappropriate administration of the Title X family planning program by the Department of Health and Human Services' Office of Population Affairs, and resist all efforts to compromise the quality, confidentiality, or scope of Title X services by opposing restrictions on family planning counseling and referral.
4. Maintain funding for the Center for Population Research within the National Institute of Child Health and Human Development at least at its Fiscal Year 1987 level.
5. Appropriate $10,000,000 for the specific development and evaluation of new or improved contraceptives.

I am Scott R. Swirling, Executive Director of the National Family Planning and Reproductive Health Association, Inc. (NFPRHA). I want to thank you and this subcommittee for the opportunity to address the issue of continued funding for programs under Title X of the Public Health Service Act, "Population Research and Voluntary Family Planning Programs."

The National Family Planning and Reproductive Health Association (NFPRHA) is a non-profit membership organization headquartered in Washington, D.C., established to improve and expand the delivery of voluntary family planning and reproductive health services throughout the United States. As the only national organization representing the entire family planning community, from consumers to state, county and local health departments; from hospital-based clinics to affiliates of the Planned Parenthood Federation of America; from umbrella funding councils to independent, free-standing family planning clinics and individual health care professionals, NFPRHA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

Title X is the primary source of federal funding for subsidized voluntary family planning services in this country. Since its inception in 1970, the national family planning program under Title X has enjoyed broad bipartisan support in Congress, and in this committee. I urge you and your colleagues to sustain that long-standing committment to quality reproductive health care for all by appropriating $160.36 million for the Title X program in Fiscal Year 1988.

Title X is a medical program serving poor Americans, but it also authorizes contraceptive research and development, and research in the reproductive and behavioral sciences. The development of improved methods of contraception could help reduce the number of unintended pregnancies in this country, which accounted for over 50 percent of all pregnancies last year. Less than ten percent of the current budget of the Center For Population Research of the National Institute of Child Health and Human Development (NICHD) goes for contraceptive development. For that reason, NFPRHA requests that Congress fund NICHD population research activities at minumum at their Fiscal Year 1987 level of approximately $120 million. In addition, NFPRHA requests that Congress grant a special additional appropriation of $10 million each year for the next four years to focus on improving contraceptive technology.

In this year of budgetary austerity, an adequate federal investment in family planning is more valuable than ever before.

Title X is a medical program that serves the poor and the medically indigent.

Title X clinics are the entry point for millions of low-income women and adolescents into the nation's health care system.

Hundreds of thousands of unintended pregnancies, many among teenagers, are averted each year as a direct result of services provided by clinics receiving Title X funds.

Federal dollars invested in Title X more than pay for themselves in savings to public health care and social service costs in the next year alone.

Typical Title X programs offer clinical health services (physical examinations, contraceptive information and services, Pap smears, sexually transmitted disease screening and treatment, cancer screening, hemoglobin tests, urinalysis, pregnancy testing and diagnosis, and basic gynecologic care); counseling services (for nutrition, infertility, parent/teen communication, maternal and child health, problem pregnancies, and related medical problems); services for men (counseling, education, condoms); special teen clinics; adolescent health education; and community education programs.

The need for continued adequate support for Title X is clear and considerable. Even with Title X, many of the 9.5 million low-income women and five million sexually-active teenagers in need of subsidized family planning services still cannot obtain medically supervised reproductive health care.

Federal, state, and local financial support for family planning has never reached a level commensurate with need. Since the early 1970's, the number of medically indigent family planning clients has grown more than 60 percent, yet federal funding for family planning has not increased in real dollars since 1973.

In the last six years, Title X's appropriation has gone from $162 million in FY 1981 to $142.5 million in FY 1987. Inflationary increases alone should have brought the current level of Title X funding to $216 million by this year. The clinics have stayed open, but the belt-tightening shows. Operating hours have been reduced, staff have been cut, and indigent patients have been asked to contribute more to the cost of services. The irony of this is, of course, that diminishing a program as effective and cost-efficient as Title X results only in far greater social and financial costs down the line.

While struggling with draconian budget cuts, Title X providers have also had to contend with inappropriate management and improper harassment from the Department of Health and Human Services' Office of Population Affairs (OPA), the federal office charged with administering the national family planning program. Through a series of inapt efforts to substitute political ideology for statutory requirements, the resources of the Department of Health and Human Services (DHHS) have been misapplied to undermine the delivery of high quality family planning services to millions of low-income women and adolescents.

I raise these concerns about the management of the federal family planning program before you today because NFPRHA understands that, as the officials responsible for appropriating millions of dollars in federal monies, you have a fundamental interest in seeing that those funds are put to work in an efficient and appropriate manner.

For more than a year, and most specifically since January 21 of this year, it has appeared that the personal anti-abortion philosophy of the Deputy Assistant Secretary for Population Affairs, Mrs. Jo Ann Gasper, and her senior advisors has distorted the administration of the Title X program -- a program designed to prevent the incidence of abortion through preventive family planning services. In media interviews, and personal appearances, Mrs. Gasper has implied that her personal loyalties and convictions lead her to implement the Title X program in a way that is in contradiction to seventeen years of Department of Health and Human Services' policy, in contradiction to DHHS General Counsel advice, and even in contradiction to the Title X statutory history and Congressional intent.

Numerous DHHS Office of the Inspector General, U.S. General Accounting Office, Congressional and other investigations and audit reviews have demonstrated strict compliance by Title X grant fund recipients with the terms, conditions and intent of the Title X statute, its regulations and guidelines regarding Section 1008 of the law (denying the use of Title X funds in programs where abortion is a method of family planning.) Nonetheless, the Office of Population Affairs has consistently attempted to force the denial of Title X funds to agencies that provide abortions with non-federal funds, or even provide non-directional counseling and referral for pregnancy termination in compliance with Title X's own rules. Mrs. Gasper's personal biases have led her to attempt to administer the Title X program in contradiction to fact and law. Despite an inability to cite any examples of violations of Section 1008 when asked to do so, Mrs. Gasper and her deputies have continued to place unwarranted emphasis on Section 1008 compliance to the detriment of other program functions of the Office of Population Affairs.

On January 21 of this year, Mrs. Gasper issued an unauthorized directive to the DHHS regional offices designed specifically to deny Title X funding to all Planned Parenthood affiliates and other Title X grant recipients that hold active pro-choice views. Mrs. Gasper's memorandum was appropriately rescinded by Assistant Secretary for Health Windom and superceded by a directive from DHHS Secretary Otis R. Bowen himself on February 5, 1987. Nonetheless, Mrs. Gasper's ill-conceived action produced a major public controversy and subsequent mass mailings to regional health offices by opponents of family planning demanding the withdrawal of federal funds from Title X projects that clearly are operating in compliance with the Title X statute and all published standards. Such a controversy - contrived as it was by an official of the Department -- severely diminishes the Public Health Service's credibility and ability to perform required monitoring and support of family planning programs. It also distracts those Title X programs from the appropriate provision of high quality services to their clients.

This emphasis on assuring abortion separation in spite of the non-existence of evidence of Section 1008 non-compliance can be seen as the implementation of personal philosophy by federal officials sworn to uphold and to administer the law. It has prevented any competent effort to address the appropriate administrative and managerial concerns facing Title X projects today. The following is only a short list of the many items of crucial importance that are being ignored or improperly handled by the Office of Population Affairs:

- The formula for allocating Title X service dollars is woefully out-of date, yet the only effort to revise it was motivated by a philosophy designed to skew funding from cost-efficient preventive family planning services requested by clients to costly, seldom requested services. So poorly-prepared was the formula that members of this committee stepped in to block its implementation during Fiscal Year 1987 with report language in the Continuing Resolution. The proposed formula took over one year to prepare and was created without active input from the family planning providers most aware of its potential implications.

- Despite the Department's and the nation's focus on AIDS, and the clear necessity for family planning agencies to address this public health threat, the Office of Population Affairs has not invested any effort in the development of information and guidance for Title X projects.

- The spread and treatment of sexually transmitted diseases such as chlamydia and penicillin resistant gonorrhea requires uniform advice from the Office of Population Affairs, yet OPA has not provided any direction to the projects it administers.

- The Office of Population Affairs has circumvented the law requiring the establishment of a National Adoption Clearinghouse and has utilized Title X funds and contracts to establish a "National Clearinghouse on Family Life Information." A clearinghouse to focus solely on the distribution of information and materials to family planning providers is required, and prior to last fall such a clearinghouse was supported by Title X funds.

- The publication of notices of requests for Title X grant applications, and the awarding of grants and contracts, has occurred consistently late, creating major dislocations for the providers of family planning services and training programs.

- Requests for grant proposals have included or atttempts have been made to include, new and unique requirements designed to limit or deny grant awards to current training and service grantees of whom OPA disapproves, despite those grantees more-than-competently meeting the terms and conditions of their current grants.

- While refusing to address current management priorities despite repeated requests from grantees for advice and assistance in those areas, the Office Population Affairs has repeatedly undertaken studies and issued directives with no apparent relationship to the direct competent provision of high quality family planning health care. These studies and directives merely foment confusion and concern in the family planning community. For example, within the last few days, OPA has solicited information from around the country regarding state laws on child abuse and statutory rape; the only conceivable purpose for the collection of such information is for the preparation of a directive designed implicitly or explicitly to circumvent the Title X program's long-standing requirements for confidential services to adolescents.

- Although limited effort is made to administer the Title X program in compliance with good management practices, OPA misspent considerable time and resources in a short-lived attempt to change the Title X guidelines regarding the provision of non-directional counseling and referral on options for the management of an unintended pregnancy in direct contravention to statutory and constitutional requirements.

- The Office of Population Affairs continues to push for the "de-funding" of agencies of which it disapproves for their involvement in abortion with non-federal funds, and is even now seeking to publish a Request for Applications for nurse practitioner and general training grants that is intended to be utilized to "de-fund" current grantees in contradiction to DHHS Secretary Bowen's February 5 memo.

Title X funds have never subsidized abortion procedures. Yet, under the guise of opposing abortion, some individuals and groups have sought to undermine the single most effective federal program for reducing the need for abortion -- Title X.

SUMMARY

Despite the attempts of the Reagan administration, the successes of the Title X family planning program cannot be ingored, and they speak forcefully for the reauthorization of Title X for three years and for NFPRHA's request that this subcommittee and Congress approve an appropriation for Title X of $160.36 million for Fiscal Year 1988 and support contraceptive development with a special supplementary fund of $10 million. Adequate funding of family planning and contraceptive research programs will send a strong message that Congress and this committee hold reproductive health care as a high priority, even in these times of fiscal constraint.

Thank you very much for your consideration of our requests. I would be happy to answer any questions you may have.

STATEMENT OF DONALD R. COHODES, ADMINISTRATOR, FEDERAL PROGRAMS, BLUE CROSS AND BLUE SHIELD

Senator CHILES. Now we will hear from Donald Cohodes, the administrator of the Federal Programs Blue Cross and Blue Shield.

Mr. COHODES. Thank you, Mr. Chairman. My name is Donald Cohodes. I am the administrator of Federal programs for the Blue Cross and Blue Shield Associations.

I appreciate this opportunity to be here to offer our comments on the administration's proposed budget for Medicare contractors.

Let me be brief and get right to the point. We believe that the administration's proposal for Medicare contractors is inadequate.

That proposal is for $1,162,000,000. It is our best estimate that it will require at least $150 million more than that to deliver the 1987 package of services in 1988.

We differ from the administration's proposal in three major categories.

The first has to do with claims processing costs. Here we believe we will need an additional $72 million above the administration's proposal. We think that the administration's proposal fails to adequately consider the impact of volume increases which are estimated at 35 million more claims, and inflation at 5 percent.

That combination of factors would argue for an increase in claims processing dollars of 18 percent. The administration has responded to those numbers by suggesting the 1 percent would be appropriate.

We believe that a 12-percent increase would be more in line with our needs.

The second area with respect to claims processing that we have a concern about has to do with the implementation of what we would consider to be a series of arbitrary cost caps on contractors.

The administration hopes to achieve $38 million worth of savings through the imposition of these caps. We did a little bit of estimation on our own. And if we take all of the contractors whose costs are above the national average, and reduce them to the national average, you still save less than half of what the administration hopes to save through arbitrary cost caps.

We think this is an indefensable posture and simply one that is ignoring budget realities and cost realities for contractors.

The second category that we have a significant difference from the administration has to do with beneficiary and provider services. Here we believe that the administration has failed to recognize the increase in inquiries and provider concerns, and appeals, that we are seeing in the system.

And we are asking for an additional $37 million to deliver, again, the 1987 service package in 1988.

The final category that we have a significant difference from the administration has to do with the contingency fund. And here too we believe from past experience that a larger sum should be appropriated.

The administration has requested $20 million; we're requesting consideration consideration for $50 million. In the last 2 years, there have been substantive changes in the Medicare Program, and we suspect that this year will be no exception, and will require those additional funds in order to meet those changes.

One of the key questions that you need to ask yourself, and what we are frequently asked, is, what do you get from investing in Medicare contractors?

And the answer is a simple one: You get a terrific value. Administrative costs for Medicare contractors are about 1 percent of the budget.

For every $1 you spend, you get $8 in return, for a total of about $11 billion return in outlay savings.

PREPARED STATEMENT

We would ask that this committee consider our request for additional funds. We ask for an additional $150 million above the administration's request to provide the 1987 package of services in 1988.

Thank you very much.

[The statement follows:]

STATEMENT OF DONALD R. COHODES

The Blue Cross and Blue Shield organization has been deeply involved in the administration of Medicare since the program's inception. Under contracts with the Health Care Financing Administration, HCFA, our Association and member Plans serve as Medicare intermediaries and carriers responsible for much of the day-to-day administration of the program. Nationally, the Blue Cross and Blue Shield system handles about 88% of Medicare Part A bills and 64% of all Part B claims.

Medicare contractors' administrative costs, as a percentage of benefit payouts, have been extremely low. In FY 1987, they represent about 1.4% of total Medicare expenditures. Administrative costs on a per claim basis also have declined dramatically, by more than 30% for Part A and nearly 20% for Part B since 1984. Additionally, the contractor system has been extremely effective at safeguarding Medicare benefit payments — resulting in savings ($11 billion in FY 1988) several times the size of the administrative budget.

The Medicare contractors have made major contributions in the fight to control the deficit both by becoming more efficient and by better safeguarding Medicare benefit dollars. We believe, however, that the Administration's FY 1988 request will reduce our ability to be helpful in this area.

The Administration's FY 1988 Budget Request

In our view, the Administration's FY 1988 budget request for Medicare contractors of $1,142 million plus a $20 million contingency fund is inadequate to meet the needs of the program and the new prompt payment standards set by Congress. The Blue Cross and Blue Shield Association recommends a total funding level of $1,311 million. We estimate that the combination of claims volume increases and inflation would necessitate an 18% increase in funding support for claims processing activities. Our request is for a 12% increase; an increase significantly less than the combination of claims volume increase and inflation. At this funding level contractors should be able to meet the new prompt payment standards and to maintain our current service levels to beneficiaries and providers.

Claims Processing

Claims processing is at the core of the contractor function. HCFA estimates savings from claims processing activities will exceed $8.4 billion in FY 1988 by preventing duplicate payments, applying reasonable charge limits, and detecting claims for non-covered care. The amounts requested and allocated by the Administration to fund this activity have not kept pace with the increasing workload and the added complexities of the claims processing operation. During FY 1984 - FY 1988 claims volume will increase at least 57%, while

HCFA's proposed funding will grow by 31% (only 10% if inflation is considered).

As prescribed by law, most of these contracts are "reasonable cost contracts." For the past three years, the contractors have been operating under arbitrary unit cost "caps" determined by HCFA. These cost caps limit the amount a contractor will receive for processing a claim regardless of the reasonable costs incurred. To achieve the savings envisioned by this new formula, all contractors, including low cost contractors, would have to reduce claims processing expenses by an additional $38 million. Even if all contractors with above average unit costs were brought down to the national average cost, only $18 million in savings would be achieved. Unit costs above the national average do not necessarily mean inefficiency. They often reflect differences in bill mix, labor costs, and in the percent of claims submitted electronically. The Administration's proposal argues that all Medicare contractors are operating inefficiently and that significant program savings can be obtained by lowering all contractors' unit costs. Such an approach is unrealistic and cannot be substantiated.

Concerns over the unit cost methodology were expressed in last year's General Accounting Office (GAO) report "Existing Contract Authority Can Provide for Effective Program Administration." GAO criticized HCFA's "cost caps" and recommended a budget development process that places "more emphasis on the individual circumstances of contractors." GAO was concerned that proposed cuts in the contractor budget would result in inaccurate and unnecessary benefit payments and in poor service to beneficiaries.

In addition to the GAO concerns, the Physician Payment Review Commission's first report cites adequate funding for claims processing as absolutely critical to protecting beneficiaries and containing benefit costs, and that funding levels "should reflect the complexity and scope of program regulations."

Beneficiary and Provider Services

The beneficiary and provider services category includes the funding necessary for contractors to respond to over 29 million inquiries, to conduct hearings and reconsiderations for appeals, and to communicate with providers regarding changes in Medicare. Although the Administration's budget displays these activities separately, funding is included in the claims processing "unit cost caps" when HCFA allocates the budgets. Consequently, reductions in unit costs make it difficult to handle the increasing number of inquiries about the ever changing Medicare program. We are recommending an additional $37 million above the Administration's request for these activities.

Payment Safeguards

The payment safeguard category includes such functions as audit, medical and utilization review, and assuring that Medicare is the "secondary payer" whenever possible. HCFA estimates savings from these activities alone will exceed $2.8 billion in FY 1988, with the average payback ranging from 5:1 to 30:1. An independent audit recently commissioned by HCFA confirmed the validity of these savings. We believe that an additional $10 million above the Administration's request can be spent effectively in the audit activity in FY 1988 to reduce backlogs of cost report audits, returning $50 million in benefit savings.

Consequences of Underfunding

Possible consequences of underfunding in FY 1988 include:

- Failure to meet the new 26 day and 19 day prompt payment standards which could result in:
  - A significant increase (on the order of $2 - 3 billion) in Medicare benefit outlays if hospitals return to the periodic payment (PIP) system because the payment standards are not met as provided in law.
  - Increased Medicare outlays associated with interest payments.
- Increased erroneous payments as a result of the possible elimination of all or some payment screens and edits not mandated by HCFA — costing Medicare much more than any administrative savings.
- Slowdown in claims payment which could cause reductions in participating physicians and in the number of physicians accepting assignment. This could increase beneficiaries' out-of-pocket costs.
- Deterioration of beneficiary services, including diminished telephone service.
- Furloughs of contractor staff.

Average Medicare Payment Times

The Administration has indicated it intends to lengthen the average payment time to 20 days from the current average of 15 to 16 days by the end of FY 1987. We understand this may involve imposing a 5 to 7 day floor on electronically transmitted claims. For FY 1988, the President's budget assumes a policy of delaying Medicare payments until at least the 24th day after receipt for most bills, and until the 28th day if Congress adopts the Administration's proposal to change the prompt payment ceilings.

The numerous changes in Medicare claims payment policies have been very disruptive to the administration of the program and have made effective planning decisions almost impossible. In our private business we do not pursue policies of purposefully delaying payments of claims and view prompt payment of claims as a feature of our service package to our customers. Also, you should be aware that the administrative costs of imposing a payment floor include additional check-writing cycles and postage costs to assure that payments are made on a specific day, computer system changes, storage costs for the additional claims that would remain in the contractor system, and costs of increased inquiries. Our budget estimate does not reflect the Administration's proposed slowdown.

Other Administrative Issues

There are two other administrative issues that are making effective planning and performance extremely difficult this year. First, although the FY 1987 Omnibus Continuing Resolution was signed on October 18, annual budgets were not provided to the contractors until late February and early March. In the interim, seven sporadic funding allocations were provided at FY 1986 unit cost levels. Because 1987 unit cost levels are lower than 1986 levels, contractors are now in the position of having to achieve significant savings during the remainder of this year to offset the higher costs incurred during the first five months.

Second, federal law requires contractor evaluation criteria to be published by October 1. This year the criteria were not finalized until March 19 — almost halfway into the year. Since a contractor's performance and effective use of budgets depends greatly on a clear understanding of the evaluation process, the late publication of performance criteria is problematic.

If the program is to be run successfully, not only will sufficient dollars need to be appropriated, but the contractors need to know in advance — preferably well before the start of the year — their individual annual budgets and the criteria upon which they will be measured. This is critical for the hiring and retaining of trained staff and the proper planning of workloads.

Conclusion

We believe the problem is that there simply are not sufficient funds for claims processing activities — the most basic and fundamental of contractor operations — and that several administrative actions are making it increasingly difficult to manage the program properly. While we believe taxpayers have a right to demand and should expect that all Federal programs are managed as effectively as possible, we believe these reductions in administrative costs proposed by the Administration are short-sighted. For these reasons, the Blue Cross and Blue Shield Association urges your favorable consideration for an FY 1988 budget of $1,311 million to fund activities performed by Medicare contractors. A detailed analysis and justification for our estimate is attached.

Blue Cross and Blue Shield Association
Recommendations on FY 1988 Medicare Contractor Budget
(Dollars in Millions)

	1988			
	Administration Request	BCBSA Recommendation	Difference	Explanation Code
Claims Processing:				
Bill/Claims Payment	$ 549.3	$ 648.5	$ +99.2	A
Provider Reimbursement	27.1	29.9	+ 2.8	A
HCFA Printing	2.3	2.3	-	
Fixed Price Contracts	88.3	58.2	-30.1	A
Total	667.0	738.9	+71.9	
Beneficiary & Provider Services:				
Hearings and Reconsiderations	36.3	50.7	+14.4	B
Beneficiary Communications	72.9	87.1	+14.2	C
Waiver of Liability	1.7	1.7	-	
Physician Participation Program	20.5	25.0	+ 4.5	D
Carrier Incentive Payments	-	4.0	+ 4.0	E
Total	131.4	168.5	+37.1	
SUBTOTAL	$ 798.4	$ 907.4	$+109.0	
Payment Safeguards:				
Medical/Utilization Review	$ 136.5	$136.5	$ -	
Provider Audits	109.5	119.5	+10.0	F
Medicare Secondary Payer	66.2	66.2	-	
Total	$ 312.2	$322.2	+$10.0	
Productivity Investments	31.2	31.2	-	
Total Operating Funds	$1,141.8	$1,260.8	$+119.0	
Contingency Fund	20.0	50.0	+ 30.0	G
TOTAL CONTRACTOR BUDGET	$1,161.8	$1,310.8	$+149.0	
Workload Consequences:				
Bill/Claims Workload Processed (in millions)	437.4	455.2	+17.8	
Opening Inventory 10/1/87	19.4	19.4	-	
Receipts	437.4	446.8	+ 9.4	
Total Available	456.8	466.2	+ 9.4	
Processed	437.4	455.2	+17.8	
Ending Inventory 9/30/88	19.4	11.0	-8.4	
Days Work on Hand	11.1	6.0	-5.1	

Explanation

A. Claims Processing: Our recommendation for bill/claims payment is $738.9 million, $71.9 million more than requested by the Administration. We believe this level is necessary to meet the new prompt payment standards enacted in the Omnibus Budget Reconciliation Act of 1986 and to assure adequate resources to safeguard Medicare benefit dollars.

Specifically, the recommended level assumes:

- Receipt and processing of more bills than the Administration's estimate for three reasons: (1) HCFA's projection of new HMO enrollees and the transfer of the associated workload from the contractors appears overly optimistic given recent experience, (2) current data indicate HCFA's 1987 bill estimates used as a base for 1988 were too low, and (3) we believe an additional 17.8 million claims over HCFA's estimates will need to be processed in order to meet prompt payment standards, especially the shortened standards for participating physicians.

- Restoring a further 10 cents a claim reduction in unit costs proposed by HCFA. We believe reductions of this magnitude are not attainable and will result in inability to properly safeguard program dollars.
- Higher inflation estimates by using estimates developed by the Congressional Budget Office, instead of the Administration's.

B. Hearings and Reconsiderations: A total of $50.7 million is recommended compared to the Administration's request of $36.3 million. The recommendation assumes receiving the same level of reconsideration requests and appeals as experienced in 1986 — 6.7 appeals per 10,000 Part A claims and 14.45 appeals per 1,000 carrier claims. Additional funds are also requested to reduce current backlogs.

C. Beneficiary Communications: Our recommendation of $87.1 million would allow prompt response to the anticipated level of beneficiary communications based upon actual 1986 and 1987 experience. Inquiries are at extremely high levels — 72 per thousand in February and these rates are expected to continue. About three-fourths of these inquiries are from beneficiaries. Also recommended is $2 million for new demonstrations to explore ways to reduce beneficiary inquiries.

D. Physician Participation Program: An additional $4.5 million is recommended to increase efforts to encourage physicians to "sign up" as "participating" physicians whereby they agree to accept "reasonable charge" levels determined by Medicare rules as payment in full for all beneficiaries for one year.

E. Carrier Incentive Payments: Our recommendation includes $4 million to provide incentive payments for carriers to increase the number of participating physicians in their area. Section 9332 of the Omnibus Budget Reconciliation Act of 1986 specifically requires these payments to be set at one percent of carriers' claims processing costs.

F. Provider Audits: A $10 million increase above the Administration's request is recommended to reduce the audit backlogs and to shorten the time between cost report submission and overpayment recovery. Audit backlogs are expected to grow as a result of unexpected FY 1987 workloads — the reopening of prior year hospital cost reports in order to make financial adjustments for new policy on Medicare reimbursed malpractice insurance and labor room days costs. The additional investment of $10 million should produce additional savings of $50 million.

G. Contingency Fund: We strongly recommend a $50 million contingency fund for FY 1988, the same level as provided in FY 1987. Given the massive and complex legislative changes enacted in each of the last few years, as well as other unexpected workloads (e.g. higher than expected claims volumes), a minimum contingency fund of $50 million is required. In FY 1987, $41 million of the $50 million contingency fund has already been allocated, most of which was allocated to implement OBRA of 1986 provisions.

Senator CHILES. Now, what kind of time will that give you with regard to turnaround on bills?

Mr. COHODES. Well, we are anticipating, at least in our budget estimates, that we will hit the guidelines that have been established in legislation, the 26 days on part A claims, and 19 days for part B.

If we do not receive this level of funding, it will be very hard to meet those dates.

Senator CHILES. Well, I notice the President's budget assumes a policy of delaying Medicare payments until at least the 24th day.

And until the 28th day, if Congress adopts the proposed change in prompt payment ceiling. We are not going to change that. But see, Congress was looking at what was a ceiling, and the administration is trying to make that a floor.

Now, I am very concerned about that, because I consider it a breach of faith from the negotiations that went on. We were starting out at 21 or 22 days. And they said, please do not impose that on us; give us the additional leeway.

We did that, and now we find them trying to make that a ceiling.

Mr. COHODES. Well, we are concerned, Senator, because we have had multiple sets of instructions—speed up claims, slow down claims, stop, do this, and do that. We would like a consistent policy, and we simply have not had it.

Senator CHILES. Well, we want a consistent policy too. And the policy is, prompt pay. With an outside thing, if the bill has to go the 26 days or something, we do not want that to be the average; we want that to be the outside.

Mr. COHODES. Well, looking at the budget request, it does not assume that at all from the administration. And basically the response will be for us to slow down claims payment to stay within our budget and to handle the workload.

Senator CHILES. What I am saying is, what kind of funding will it take to see that we do not have that, that we have the Congress' policy, because Congress is the one trying to set the policy.

Mr. COHODES. The size of the budget request that we have recommended is one that would enable us to process claims properly. Which is, we are requesting an additional $150 million, and specifically, an additional $72 million for claims processing.

And we could then, we believe, meet the claims processing timeliness guidelines, which are now in the law.

Senator CHILES. But you would not have any kind of mandatory delay, or somebody sitting down and saying, I have got to hold this claim awhile before I can work it?

Mr. COHODES. We do not control that. The administration provides us with guidance on this. We are contractors, and they could institute a floor to us, and tell us, as they have already——

Senator CHILES. They can do that. I am asking you, from the funding standpoint.

Mr. COHODES. From the funding standpoint, their recommendation is not sufficient. And we would need additional dollars.

Senator CHILES. All right. Come back to my question now. You said, giving you the additional money would allow you to make prompt pay.

Mr. COHODES. Yes, sir.

Senator CHILES. Now, does that mean that your people will be working to get a claim out as fast as they can? And no one will be sitting there deliberately holding—now if they send you down a guideline, then we have to take that on. I understand that.

I am asking from the monetary standpoint. Because the way they ultimately get their way, I think, is they dictate it by cutting your funds, or shutting down the funds.

We will take them on on the fine things.

Mr. COHODES. Yes, sir; if we had that level of funding, we would be able to pay claims promptly.

Senator CHILES. The other thing is, if these other guidelines come down, regardless of how they are couched, we need to know about them. Because we want to be able to know about that.

Mr. COHODES. We will keep the committee informed.

Senator CHILES. Thank you.

Mr. COHODES. Thank you.

STATEMENT OF LUTHER E. CARTER, HEALTH INSURANCE ASSOCIATION OF AMERICA

ACCOMPANIED BY ARTHUR LIFSON, VICE PRESIDENT, EQUICOR, INC.

Senator CHILES. Now we will hear from Luther Carter, with Health Insurance Association of America.

Mr. CARTER. Mr. Chairman, I am Luther E. Carter, vice president of the Travellers Insurance Co.

With me today is Arthur Lifson, vice president of Equicor, Inc.

We are presenting our statement today on behalf of the Health Insurance Association's eight members, who are the commercial companies that are carriers and the intermediaries in the Medicare Program.

I would like to say that we fully support the testimony just given by the previous witness. We agree with the question, the answers, that he has had to your questions.

So I will dispense with repeating the things that he has just said. Instead, I would like to take a little bit different tack here, and point out another part of the problem that we face, that is causing some of the things, I believe, that your questions were leading to.

There are those in the Federal Government that manage the funds who are also trying to manage the day-to-day operations of the Medicare Program. And of course I do not believe that they have a real—or seemingly do not have a concept of what the decisions they make have on the elderly beneficiaries.

There seems to be a feeling among those who manage the funds that there has to be a mass exodus of Medicare contractors from the program. They use the term, blood on the floor, before they will believe that costs have been driven to the absolute lowest point possible.

They do not seem to believe also the dedication of all of the Medicare contractors that have been in the program since its existence.

We are determined, those contractors that are in the program, that we are not going to be driven out and leave the program to the inefficiencies of the Government. The budget process, the management process of the budget is in serious trouble.

And just as an example, last year, the continuing resolution was signed by the President on October 30, I believe, 1986. The Medicare contractors did not get notice of budget approval until mid-February.

So you can see all of the turmoil that these kinds of things can have.

During this period between October 1, 1986, and mid-February when we got budget approval, contractors were utilizing their own funds in many cases to keep this program going. There are instances where contractors outlaid several millions of dollars of their own funds to keep the program going because of these controversies going on within the administration on the budget process.

That is even after you have taken your actions. In conclusion, I would just like to say that I agree completely with the request that my predecessor here has made. Our numbers correspond very closely to his.

And we would recommend that this committee consider additional funds for the Medicare Program so that it can be carried out in a manner that would be satisfactory.

Thank you Mr. Chairman.

PREPARED STATEMENT

Senator CHILES. We thank you for your appearance and for your testimony.

When these delays are occurring in the future, let our staff know about that. I would like to know at the outset how those are happening and where those delays are.

Mr. CARTER. Yes, sir. Thank you.

[The statement follows:]

Statement of Luther E. Carter

Mr. Chairman and Members of the Subcommittee, I am Luther E. Carter, Chairman of the Medicare Administration Committee of the Health Insurance Association of American (HIAA) and also Vice President, Medicare Administration, for The Travelers Companies. With me is Arthur Lifson, Vice President, EQUICOR, Inc. This statement is presented on behalf of HIAA'a Medicare Administration Committee representing the eight member companies[1/] that have served as Medicare carriers or intermediaries since the inception of the Medicare program in 1966.

The Medicare program has been a successful, cooperative effort, jointly administered by the federal government and private companies on a contractual basis of no profit/no loss. Medicare contractors handle an enormous workload -- an estimated 436 million claims and approximately $90 billion in benefits in F.Y. 1988 -- providing a high level of service with dependable quality controls, incurring administrative costs of 1.1% of benefit payments. This is a truly remarkable record and a tribute both to the Health Care Financing Adiminstration (HCFA) and the private sector contractors who operate the program. Medicare is one of the few government programs that has continuously and consistently demonstrated reduced administrative costs per claim.

Our concern is that adequate funds be appropriated to enable the carriers/intermediaries to pay beneficiary claims promptly while administering the Medicare program effectively and efficiently. As Congress considers proposals to change the Medicare program (e.g. catastrophic), we believe HCFA must evaluate the need for substantial increases in administrative costs. A prime example is beneficiary communications. The

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[1/] These companies include: Aetna Life and Casualty; EQUICOR, Inc.; General American Life Insurance Company; Mutual of Omaha; Nationwide Mutual Insurance Company; Occidental Life Insurance Company of California; Prudential Insurance Company of America; and The Travelers Companies.

Medicare carriers and intermediaries project that with these changes there will be substantial increases in utilization once the out-of-pocket expenses are met. If changes are to be made in the services provided by Medicare, corresponding dollars for administrative costs must be allocated.

We commend the Administration's effort to control budget outlays. However, budget reductions should not be at the expense of the elderly and the physicians/providers who render the service to them. To deliberately delay the payment of claims causes the beneficiary to subsidize the budget reduction by virtue of a "float" (an interest-free loan) imposed by the federal government. Further, Medicare pays less than 50% of the beneficiaries' total bills. In most instances, other payors will not process claims until Medicare has determined its payment. This penalizes the Medicare beneficiary twice.

Fiscal Year 1988 Budget Request

The Administration has requested a total budget for FY 1988 of $1,142 million, plus a contingency fund of $20 million. This request is inadequate for many reasons.

Estimated workload is understated

Claim workload has risen an average of over 11% annually over the last five years. There is no reason to believe that 1988 will be significantly different. However, HCFA's projections do not reflect this level of increase. This lack has led to HCFA's consistently underestimating actual claim workload for each year, placing the contractors in the untenable position of having to process increased claims with insufficient funds.

By deliberately understating the workload, HCFA expects the contractors to process any additional claims volume over their estimates as "incremental" workload, which is reimbursed at 75% of normal costs. This is shown in their budget document as "25%

Productivity Gain (incremental workload)" with a purported budget savings of $23.6 million for processing additional volume.

Inflation estimates are low

Inflation is projected at 3.7%. This projection is substantially below the Congressional Budget Office estimate and far below current indicators. Secretary Baker's campaign to weaken the dollar on the international market marked a change in the philosophy that has governed the rate of inflation since the early 1980's. We would recommedn that HCFA develop a price index that more accurately reflects the changes in costs of the goods and services purchased by contractors. Just as benefit payment estimates always include an adequate allowance for inflation, so should claims administration expense estimates.

Reductions in unit claim costs based on Market Price Standard

HCFA's "market price standard" is purported to save $37.5 million in FY 1988. However, Medicare carriers/intermediaries have been unable to get a clear definition of "market price standard." It is generally understood that this standard price is based on an average price obtained from the limited number of competitive contracts let by HCFA, but the methodology is very questionable. Most of the contracts HCFA let for competitive bid resulted in proposals based only on incremental costs (i.e., the agreed price did not include overhead costs). Medicare contractors have continually advised HCFA that these bids do not reflect total costs, but are based on marginal costs (i.e., without overhead). Also, the bid price does not necessarily reflect the final cost to HCFA (overtime costs, etc.). To use the marginal cost of a limited number of competitive contracts as the basis for determining the average cost cap for all contractors would significantly reduce the level of service to beneficiaries and encourage the formation of a few very large carriers.

OBRA Mandated requirements re: timeliness of payment

The statute requires that 95% of all clean claims be paid within 26 days in FY 1988. The Administration's budget request seems to indicate a pending inventory of 19.4 million claims at the end of FY 1988. This is equivalent to 11 days work on hand (DWOH). Medicare contractors are finding that even to meet the 30 day standard set for FY 1987, the inventory of pending claims must be in the range of five to seven days. There are at least five days of claims on hand not accounted for in the Administration's budget request.

The Medicare Administration Committee and the companies it represents endorse reducing the federal budget. However, if it is to be done in this manner, it should be done openly. To do otherwise puts an unfair burden on the beneficiaries and the contractors that administer the program.

Enrollment estimates for HMO/CMP are overstated

The enrollment estimates for HMO/CMP are substantially overstated. The first HMO/CMP contract was in place in April 1985, but enrollment has only reached 3.5% over a two year period. HCFA's budget estimates indicate that they are projecting a dramatic increase in enrollment that we believe is unfounded. Not only has the enrollment been overstated, but they have over estimated the number of services per enrollee as well.

Prompt Payment of Claims

Early in the debate on prompt payment, everyone disavowed any intention to deliberately delay claim payments to improve the trust fund balance. The Grace Commission's suggestion to do this was soundly rejected by Congress. In 1986, HCFA's proposal to let pending claims grow as an administrative cost savings was also rejected by Congress. In 1986, Congress appropriated additional funds to improve claims processing service to beneficiaries with strong language as to how the funds were to be utilized; yet the controversy goes on.

Medicare carriers are now advised that the name of the game is total budget outlays and that administrative costs are secondary. The migration from a traditional service oriented claims process to a cash management approach has been extremely difficult for Medicare carriers and intermediaries.

During Senate questioning, HCFA responded that it would cost the government $200 million per day in benefit payments and $6 million per day in extra contractor expense to lower the national average of claim processing time from 20 days to 15-16 days. 1/ However, contractors cannot meet the prompt payment standards without lowering the claims processing time.

The delayed payment of claims has been defined and redefined depending on the moment. We had Days Work on Hand (DWOH), we had Processing Payment Cycle (PPC), and we now have Claims Processing Timeliness (CPT). New definitions are thrown out to confuse the issue. The bottom line remains: claims are being delayed to control total budget outlays including benefit payments to beneficiaries and providers.

Budget Management causing serious problems

The successful administration of the Medicare program mentioned above was achieved through a cooperative effort with the federal government. This cooperative effort has begun to break down and is being replaced by an adversarial relationship. The success achieved over the years was based on mutual trust, a very necessary ingredient for a program of this nature.

HCFA has focused so earnestly on cost cutting that it is operating in isolation. Contracts between the government and Medicare contractors are being disregarded in the area of budget negotiations. Instead of following the contractual procedures, HCFA is using inequitable formulas to arbitrarily set the unit costs of processing Medicare claims.

1/ Senate Subcommittee on Labor - HHS - Education Hearing March 3, 1987

The FY 1987 budget process is a prime example of the problems that exist. The Continuing Resolution (PL 99-591) was signed by the President on October 30, 1986, yet Medicare contractors did not receive Notice of Budget Approvals (NOBA's) until mid-February, 1987. Even today, many areas of the budget are not clear to the contractors.

During the period between October 1, 1986, and mid-February, 1987, many Medicare carrier/intermediaries -- because of delayed funding authorizations -- utilized their own funds to keep the program going, amounting in some cases to a loan of several million dollars to the federal government.

In summary, the Medicare program provides a necessary service to millions of beneficiaries each year. Medicare contractors and intermediaries have worked very hard in conjunction with HCFA to bring down the administrative costs of the program. Further cuts and procedures proposed by HCFA will severely effect the service to the beneficiaries. We have touched only on a part of the total budget, that of paying claims properly and promptly. Our analysis of the proposed budget ($1,142 million) and the needs of the Medicare contractors indicates a shortfall of $131 million. We strongly recommend that this Committee consider a budget of $1,273 million, plus a $50 million contingency.

STATEMENT OF MARY F. BUESTRIN, CHAIRMAN, NATIONAL ADVISORY COUNCIL ON CONTINUING EDUCATION

Senator CHILES. Now we will hear from Mary Buestrin, the chairman of the National Advisory Council on Continuing Education.

Ms. BUESTRIN. Mr. Chairman and members of the subcommittee, my name is Mary Buestrin, and I am the chairman of the National Advisory Council on Continuing Education, which is a statutory independent establishment of the U.S. Government consisting of 12 public members and 8 Federal agencies.

It is the only Federal entity charged, by law, with overseeing the coordination and improvement of the approximately $50 billion annual Federal investment in renewing America's human resources through continuing, recurrent, education and training.

Congress has instructed us to review the operation, efficiency, and policy rationale of the programs and budget authorities under which this investment is made.

Such governmentwide examination, transcending boundaries of agency or subcommittee jurisdiction is a mandate assigned uniquely to this council.

Direct Federal expenditures are about $30 billion through nearly 400 separate programs. In addition, Federal policies create significant incentives for employer and private citizen investment.

For-profit employers spend over $40 billion annually on continuing education and training. This human capital investment is a tax-deductible business expense. Therefore, tax revenues are intentionally reduced an additional $20 billion.

An additional several billion is invested by individuals and tax-exempt organizations.

I am pleased to report to you, now the preliminary results of our current research. America has in place the most sophisticated Federal policy and the highest rate of continuing education expenditure of any industrialized nation.

We have a Federal human capital investment policy. It consists of a mosaic of laws and policies for Federal investment in human capital through continuing education.

The wisdom of this approach is that investment decisions have been made where intelligence and informed decisions can best be made by a specific congressional subcommittee or Federal agency, a field extension office, or an individual company or person.

It is in this decentralized fashion that wise judgments have been made about the ability of a particular continuing education investment to contribute to the solution of a social problem, or the achievement of a national objective.

The council is assessing how these Federal continuing education human capital investment expenditures, fragmented by diverse legislative authority, agency responsibility, and congressional committee jurisdiction, can better coordinate and focus on future national problems, and how the Nation's overall human capital investment strategy can be strengthened.

We see this subcommittee, and the full Appropriations Committee as a principal user of the results of our analyses. And we want to work closely with your staff over the coming year.

What do we seek to accomplish by investing this money to develop our human capital? We invest to increase employability and mobility, and to reduce social dependency; to foster economic development in rural America; to encourage entrepreneurship; to retrain workers for future skill shortages; and to compensate for industrial dislocation.

To increase our Nation's international competitiveness and productivity; and in helping older Americans retain their financial independence.

In the interests of time, I will not go through the specific dollar amounts, but we have included these figures in the document which we are submitting for the record.

Let me recap the work we are doing this year which will be of use to you. We will provide you with baseline data on human capital investment expenditures, analyzed by social purpose, in addition to typical budget functions, agency programs, et cetera.

We will recommend to you, in the authorization committees of the Senate, ways to increase the efficiency and effectiveness of government programs and expenditures.

We will publish data on international comparisons of the human capital investments policies of industrialized nations; and we will recommend and spotlight ways that new partnerships and new technologies can increase the yield from our human capital investment.

We have instructed our staff to work with your staff as closely as possible on each of these matters, and we ask for your cooperation.

The human resource aspects of several current problems demand a governmentwide approach. We need to get the most out of every dollar we invest.

The National Advisory Council on Continuing Education wants to assist this committee, and other congressional committees, by producing a unique governmentwide analysis of our Federal investment to develop America's human capital resource.

We want our data and analysis to be useful to you as you allocate funds. Investment in our human capital resource may be the most important item on our national agenda.

PREPARED STATEMENT

Thank you for this opportunity to testify.

Senator CHILES. Thank you.

[The statement follows:]

STATEMENT OF MARY F. BUESTRIN

Mr. Chairman and Members of the Subcommittee, my name is Mary F. Buestrin and I am the Chairman of the National Advisory Council on Continuing Education which is a statutory, independent establishment of the U.S. government. It is the only federal entity charged, by law, with overseeing the coordination and improvement of the approximately $50 billion annual federal investment in renewing America's human resources through continuing, recurrent education and training. Congress has instructed us to review the operation, efficiency and policy rationale of the programs and budget authorities under which this investment is made. Such government-wide examination, transcending boundaries of agency or Subcommittee jurisdiction, is a mandate assigned uniquely to the Council.

My testimony will focus on three parts:

-- the sophisticated mosaic of federal investment in human capital;

-- the reasons we invest and how much; and

-- the work we have in progress.

Direct federal expenditures are about $30 billion through nearly 400 separate programs. In addition, Federal policies create significant incentives for employer and private citizen investment.

For-profit employers spend over $40 billion annually on continuing education and training. This human capital investment is a tax deductible business expense. Therefore, tax revenues are intentionally reduced an additional $20 billion.

An additional several billion dollars is invested by individuals and tax-exempt organizations.

I am pleased to report to you now the preliminary results of our current research. America has in place the most sophisticated federal policy and the highest rate of continuing education expenditure of any industrialized nation. We have a federal human capital investment policy.

It consists of a "mosaic" of laws and policies for federal investment in human capital through continuing education. The wisdom of this approach is that investment decisions have been made where intelligent and informed decisions can best be made -- by a specific Congressional subcommittee, a federal agency, a field Extension office, or an individual company or person. It is in this decentralized fashion that wise judgments have been made about the ability of a particular continuing education investment to contribute to the solution of a social problem or the achievement of a national objective.

The Council is assessing how these federal continuing education/human capital investment expenditures -- fragmented by diverse legislative authority, agency responsibility, and Congressional committee jurisdiction -- can better coordinate and focus on future national problems, and how the nation's overall human capital investment strategy can be strengthened. We see this subcommittee and the full Appropriations Committee as a principal user of the results of our analyses and we want to work closely with your staff over the coming year.

I'd like to share with you some of the data beginning to emerge from our research which is looking at the entire range of Federal activities, ignoring agency boundaries. To date, we have documented $23 billion of the continuing education portion of the federal budget. Added to this is the $20 billion of tax subsidy. We believe the final total will be over $50 billion through about 400 separate legislative authorities and through every agency of the government.

What do we seek to accomplish by investing this money? What are the objectives of our federal human capital investment policy?

** We invest to increase employability and mobility and to reduce social dependency. ______% $_______

** We invest to foster economic development in rural America. ______% $_______

** We invest to encourage entrepreneurship. ______% $______

** We invest to retrain workers for future skill shortages and compensate for industrial dislocation. ______% $______

** We invest to increase our nation's international competitiveness and productivity. ______% $______

** We invest in helping older Americans retain their financial independence. ______% $______

** We invest in keeping professionals up-to-date. ______% $______

** And, we have tax policies which encourage financing human capital investments in the federal, state, and private sectors, primarily related to education and training to help people do their jobs better and their employers compete better.

Let me recap the work we are doing this year which will be of use to you --

We will provide you with baseline data on human capital investment expenditures analyzed by social purpose in addition to typical budget functions, agency programs, etc.

We will recommend to you and the authorization committees of the Senate ways to increase the efficiency and effectiveness of government programs and expenditures.

We will publish data on international comparisons of the human capital investment policies of industrialized nations.

And, we will recommend and spotlight ways that new partnerships and new technologies can increase the yield from our human capital investment.

We have instructed our staff to work with your staff as closely as possible on each of these matters and we ask for your cooperation.

The human resource aspects of several current problems demand a government-wide approach. We need to get the most out of every dollar we invest.

The National Advisory Council on Continuing Education wants to assist this Committee and other Congressional committees by producing a unique government-wide analysis of our Federal investment to develop America's human capital resource.

We want our data and analysis to be useful to you as you allocate funds.

Investment in our human capital resource may be the most important item on our national agenda.

Thank you for this opportunity to testify.

Senator CHILES. Tell me something about your staff. What kind of staff do you have, and how are you funded?

Ms. BUESTRIN. We are funded through the S&E budget of the Department of Education. We do not have specific funds allocated to our commission.

Senator CHILES. What kind of staff do you have?

Ms. BUESTRIN. We have a full-time executive director, and three part-time and one full-time assistants that do research, are research assistants.

Senator CHILES. This information that you are going to put together, how are you going about doing that? Do you have other people on loan to you?

Ms. BUESTRIN. No; actually, our staff is working with all the other Federal agency members that are members of the council, and coordinating all the information that is gleaned for this report through them.

Senator CHILES. Who makes up the council?

Ms. BUESTRIN. The council is made up of 12 public members that are Presidential appointees, and then the 8 Federal members representing Defense, Health and Human Services, OPM, VA, Agriculture.

Senator CHILES. How often does the council meet?

Ms. BUESTRIN. We are mandated by Congress to meet twice a year. In the past we have tried to meet four times a year, because we do not feel that twice is enough time.

Last September, the entire council members came in for a meeting at their own expense.

Senator CHILES. How long do these meetings last?

Ms. BUESTRIN. Normally, it is a day and a half.

Senator CHILES. And how long has the council been in existence?

Ms. BUESTRIN. Gosh, I do not know that.

Senator CHILES. A long time?

Ms. BUESTRIN. Yes; it has been. I'm told it is 1971. Most of the members that are on right now were appointed in 1982.

Senator CHILES. How long are they appointed for?

Ms. BUESTRIN. It is a 3-year term. Some have been reappointed. I for one was reappointed in 1985.

Senator CHILES. Is there no limit to the number of reappointments?

Ms. BUESTRIN. Right. There are some vacancies on the council right now that have not been filled by the White House.

Senator CHILES. How many vacancies?

Ms. BUESTRIN. I believe there is one at this point.

Senator CHILES. Thank you very much.

STATEMENT OF SANFORD F. KUVIN, M.D., PALM BEACH, FL

Senator CHILES. We will now hear from Dr. Sanford Kuvin of Palm Beach, FL.

Dr. KUVIN. My name is Dr. Sanford Kuvin. I am clinical associate professor of medicine at the Uniform Services University in Bethesda, and I am also a clinical associate at the University of Miami.

And I am chairman of the International Board of the Kuvin Center for the study of infectious and tropical diseases. My residence is Palm Beach, FL.

My purpose in being here today is to present to you a progress report about the Fogarty International Center, a research and support division in the National Institutes of Health which furthers international cooperation and collaboration through its post-doctoral fellowships and research programs, through its senior scientist exchanges between the United States and other countries; through its capability to serve as a focal point for foreign visitors to the National Institutes of Health; and through its ability to coordinate NIH binational and international activities.

Well, what has the Fogarty accomplished? And where does it go from here?

Since 1969, over 130 distinguished scientists around the world have received the esteemed Fogarty scholar-in-residence award. Over 2,300 Fogarty International research fellowships have been awarded to scientists in more than 50 countries.

And 550 U.S. scientists have conducted research in 35 countries abroad under the Fogarty Senior International Fellowship Program.

Because of the very modest budget of the Fogarty International Center of only $9 million, the potential for this national treasure has not yet been realized.

For example, the number of Fogarty scholars and residents at any one time at the Fogarty International Center should be enlarged to properly interact.

The Fogarty International Center is currently providing, through its International Studies Program, a series of studies to determine the feasibility of control or eradication of tropical and infectious diseases, which cause more death and disability in this world than all other diseases combined.

This International Studies Program is in need of strengthening as well. There is also no mechanism in the Fogarty budget to fund senior foreign scientists to come to U.S. institutions for collaborative research activities, where the sharing of knowledge in a complementary way will enhance the national health interests of the United States.

There is similarly no mechanism to send junior U.S. scientists abroad to take advantage of research experiences only available in other countries.

It is imperative that our young scientists have the opportunity to study abroad in areas where disease patterns are different, so they may bring their experiences and knowledge back to the United States to benefit the health of the American people.

I certainly do not have to tell this committee that AIDS is like the mythical Andromeda strain that has escaped its environment; and it is the most important disease to enter into our society in at least the last 100 years.

The Fogarty International Center is currently offering two institutional AIDS fellows, from the expected fiscal 1988 budget, but has already had over 60 inquiries for additional institutional Fogarty AIDS fellowships.

The Fogarty International Center needs, and should be given, the $2 million additional funding for institutional Fogarty AIDS fellowships in fiscal 1988 to meet this extraordinary demand for our national needs, in addition to other supplement appropriations requested.

In conclusion, the essential elements of the dream and vision by Congressman Fogarty are in place, but in order to be the great international center that Congressman Fogarty envisioned, and a great U.S. national resource in international health matters, the Congress will hopefully continue to expand its support for development of existing Fogarty programs; for the development of the International Studies Program, the expansion of the Fogarty scholars and residents building on the NIH campus; for funds for junior U.S. scientists to go abroad; and for senior foreign scientists to come to the United States; and particularly, for the $2 million additional request for fiscal 1988 for institutional Fogarty AIDS fellowship monies and other supplemental appropriations requested.

PREPARED STATEMENT

Senator Chiles and members of the committee, I am no political scientist. But I am a physician and a medical scientist. And I know that the programs envisioned in the dreams of Congressman Fogarty are the best prescription for the health of the American people in the world we live in.

Thank you.

Senator CHILES. Thank you, sir.

[The statement follows:]

STATEMENT OF DR. SANFORD F. KUVIN

My name is Dr. Sanford Kuvin. I am clinical associate professor of medicine at the Uniformed Services University in Bethedsa, clinical associate professor at the University of Miami, I am on the board of trustees of the National Foundation for Infectious Diseases, and I am the chairman of the International Board of the Kuvin Center for the Study of Infectious and Tropical Diseases of the Hebrew University of Jerusalem. My residence is Palm Beach, FL, and my purpose in being here today is to present to you a progress report about the Fogarty International Center [FIC], a research and support division in the National Institutes of Health which further international cooperation and collaboration through its research programs, conferences and seminars, through its postdoctoral fellowships for research experience in the United States and abroad, through its senior scientist exchanges between the United States and other countries, through its capability to serve as a focal point for foreign visitors to the National Institutes of Health, and through its ability to coordinate NIH binational and international activities. The director of the Fogarty International Center, Dr. Craig Wallace, is the Institute Director at the NIH who also serves as the Associate Director for International Research of the entire NIH, and, therefore, acts as a major source of advice to the NIH Director, Dr. James Wyngaarden, on all matters related to international health.

International health is terribly important to the health of the American people since viruses, bacteria, and parasites need no passports, and a mosquito does not recognize an international border when it sees one. U.S. Congressman John E. Fogarty had enormous vision in 1963 when he foresaw a great international center in Bethesda which would ultimately become a great national resource of the United States to deal with international medical problems as they affect the health of the American people. For example, these medical diseases which are dealt with at the FIC recognize no border, are important not only medically, but also are important economically, socially, and politically. Malaria killed almost 2 million people last year with almost 200 million cases worldwide. AIDS has been identified by President Reagan as public health enemy No. 1, and is now reported in over 100 countries with 2 million viral carriers in the United States and many more millions worldwide. Diarrhoeal diseases kill over 6 million African children each year, and rotovirus infections in children, amongst other diarrhoeal disorders, is now a problem in the United States as well. The B form of infectious hepatitis is the precursor of the second commonest cancer in the world, primary carcinoma of the liver. Recently, the Institute of Medicine in association with the Board of Science and Technology for International Development of the National Research Council published this month an important monograph addressing the need of the United States to maintain its expertise in international health as a national resource and as a priority benefiting one-half of the 4.9 billion people on this Earth affected by these diseases, including the health of the American people. The FIC is trying to accomplish these goals of improving international health and the health of the American people by attempting to reach the potential of this Center developed to honor Congressman Fogarty.

Well what has the Fogarty accomplished, and where does it go from here.

Since 1969 over 130 distinguished scientists around the world have received the esteemed Fogarty Scholar in Residence Award, over 2,300 Fogarty international research fellowships have been awarded to scientists in more than 50 countries, and 550 U.S. scientists have conducted research in 35 countries abroad under the Fogarty Senior International Fellowship Program.

Because of the modest budget of the FIC of only $9 million, the potential for this national treasure has not yet been realized. For example, the number of Fogarty Scholars in Residence at any one time should be enlarged to properly interact. Attaining this level could be achieved if funding for office and laboratory facilities to accommodate them could be secured. Congressman Fogarty also envisioned an International Study Center at the FIC as part of his concept to provide interdisciplinary scholarships which would bring distinguished scientists together in search of solutions to health problems that are international in scope. The FIC is currently providing through its International Studies Program a series of studies to determine the feasibility of control or eradication of tropical and infectious diseases which cause more death and disability then all other diseases combined. This International Studies Program is in need of strengthening, but again the budget history of the FIC precludes significant further development in these areas which were so important to the visions of Congressman Fogarty. Although the Fogarty Fellowship Program functions through its international research fellowships, through the Senior International Fellowship Program, and through the Scholars in Residence Program, there is no mechanism for funding senior foreign scientists to come to U.S. institutions for collaborative research activities where the sharing of knowledge in a complimentary way will enhance the national health interests of the United States. There is similarly no mechanism to send junior U.S. scientists abroad to take advantage of research experiences available in other countries. Whether it be malaria, AIDS, diarrhoeal disorders, or B hepatitis, it is imperative that our young scientists have the opportunity to study abroad in areas where disease patterns are different, so they may bring their experiences and knowledge back to the United States to benefit the health of the American people. AIDS is like the mythical Andromeda strain that has escaped its environment. It is the most important disease to enter society in at least the last 100 years. The FIC is currently offering two institutional AIDS fellowships from the expected fiscal year 1988 budget, but has already had over 60 inquiries for additional Fogarty institutional AIDS fellowships. The FIC needs and should be given $2 million in additional funding for institutional Fogarty AIDS fellowships in fiscal year 1988 to meet this extraordinary demand on our national needs in addition to the other supplemental appropriations which have been requested.

The essential elements of the dream envisioned by Congressman Fogarty are in place at the FIC—but in order to be the great international center as Congressman Fogarty envisioned it, and a great U.S. national resource in international health matters, the Congress will hopefully continue to expand its support for development of existing FIC programs, for the development of the International Studies Program, for expansion of the Scholars in Residence building on the NIH campus, for funds for junior U.S. scientists to go abroad, and for senior foreign scientists to come to the United States, and particularly for the $2 million additional request for fiscal year 1988 for the institutional Fogarty AIDS fellowship moneys and the other supplemental appropriations requested.

I am no political scientist, but I am a physician and a medical scientist, and I know that the programs envisioned in the dreams of Congressman John E. Fogarty are the best prescription for the health of the American people, in the world we live in.

Senator CHILES. Does the Center get any funding other than its governmental funding?

Dr. KUVIN. No, sir.

Senator CHILES. How long has the Center been in being now?

Dr. KUVIN. Well, Congressman Fogarty died in 1963.

Senator CHILES. 1963? And the Center is located at——

Dr. KUVIN. It is on the campus of the National Institutes of Health. It occupies two geographic locations. One is building 38A next to the National Library, and also Stonehouse is the residence for the Fogarty scholars in residence which come from abroad.

Senator CHILES. Thank you very much for your testimony. Appreciate your appearance here.

SUBCOMMITTEE RECESS

The subcommittee will stand in recess until 2:30 this afternoon in Dirksen 124 to hear public witnesses testimony on the Alcohol, Drug Abuse, and Mental Health Administration.

[Whereupon, at 11:50 a.m., Thursday, May 7, the subcommittee was recessed, to reconvene at 2:30 p.m., the same day.]

(AFTERNOON SESSION, 2:30 P.M., THURSDAY, MAY 7, 1987)

The subcommittee in room SD–124, Dirksen Senate Office Building, Hon. Pete Domenici presiding.

Present: Senators Chiles, Hollings, and Domenici.

NONDEPARTMENTAL WITNESSES

Senator DOMENICI. Could we have the subcommittee come to order.

Senator Chiles, as chairman of this subcommittee, has asked me to preside temporarily this afternoon in his absence. I will try to do that and do it as best I can.

He might very well be back here shortly. But this afternoon the subcommittee will continue with public witness hearings focusing on programs under the jurisdiction of the Alcohol, Drug Abuse, and Mental Health Administration.

This week the subcommittee will hear testimony from 200 witnesses, and because of the large number of witnesses, we must request with regret that each witness keep their oral testimony brief.

Your full statements will be included in the record. It would serve your purpose best if you call our attention to the most important matters in your statement. But obviously the entire statement will be available for the staff and Senators.

To help us stay on schedule we will use a procedure by which this red light goes on. When that happens, we do not have a yellow light. When the red light goes on your time has expired.

We need to do this so that each witness will have a fair opportunity to he heard. The committee is pleased to have as its first witness Dr. Herbert Pardes, vice president of the American Psychiatric Association. We welcome you again, Doctor, and if you would please proceed.

STATEMENT OF DR. HERBERT PARDES, VICE PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. PARDES. Senator, it is a pleasure to be here, a pleasure to present to you, and I appreciate, we all do, your unique leadership in this area.

The situation regarding psychiatric research is both extraordinarily exciting on the one hand and disturbing on the other. Within the last several months there have been major discoveries of genetic etiology for Alzheimer's Disease and also for manic-depressive disease, two genes for manic-depressive disease, which shows that this is a collection of psychiatric disorders.

The excitement in the field is also conveyed in the current article in Newsweek, demonstrating some of the advances in the treatment of depression.

It is also demonstrated in some of the technological advances which are showing the possible role of dopamine receptors in schizophrenia, and also beginning to use the genetic techniques for affective disorders and for Alzheimer's Disease to apply to diseases like schizophrenia.

There are many other tantalizing developments, Senator, which time precludes my elaborating. Suffice it to say that it is a unique time in psychiatric research.

These are hopeful possibilities, they are just possibilities. But we think there is good reason to be optimistic. That is the good news.

The bad news is that repeatedly scientists with top priority scores in the 130's and 140's are uncertain of funding and sometimes do not receive it. One of the finest epidemiology programs in the country received a 105 priority score, which is like getting an A plus, but still did not get fully supported with that program.

We are starting to see more young people interested in psychiatric research come to the field. But because of insufficient money we are concerned that we be able to have them really reach their promise.

One needs money for the infrastructure for research, for the technology, and the many things that make research happen. In review of all the Lasker awards, Dr. Louis Thomas stated that this decade is already providing its own evidence that neurobiology is well underway as the most exciting of all fields in biological science.

It seems safe to predict from today's vantage point that the events that lie in the decades ahead will almost certainly revolutionize all our earlier notions about the brain and about the mind that it operates or that operates it.

How are we to realize that unless there is adequate support? The Institute of Medicine says there should be more support in this area. So does the Ad Hoc Group for Medical Research Funding. And citizen groups are stating that research is one of their highest priorities.

The statistics I will not review. They are in the full statement, Senator. The problem is substantial.

Senator, in 1984 I moved from the Government, where I was Director of NIMH to a research and university center at Columbia University and the New York State Psychiatric Institute. Psychiatric academicians are excited about the opportunities and hopeful that the next decade or two will mean enormous advances. But the critical support has to be there.

Specifically, we are concerned about an increase of support for research training. We are asking for a $9 million boost in research training. The Institute of Medicine said there should be some 300 physician investigators in this field. Currently there are only about 69 being supported.

We need support for the full funding of clinical research centers. In order to really attack these problems one needs total expertise, and that is best handled through some of the research support programs.

The support of the Research Scientist Development Award, and the first Independent Research Award are awards which allow young clinical researchers to truly allow their areas or their research to bloom.

In clinical training there a number of manpower issues we need to cover, but I do want to emphasize that one has to tailor the program to the area. In the field of psychiatry, the most critical need is for faculty in order to be able to launch programs which are usually underfunded.

I want to make one note regarding the NIMH's schizophrenia research initiative. This is dramatic. It is an excellent plan for mounting a major attack on the dreaded disease.

It involves clinical research centers, technology, coordinated brain, gene, and tissue banking systems, recruitment, and retention of young and senior investigators to the field of schizophrenia research, and the full application of neuroscience, epidemiological, and brain behavior technologies.

Finally, Senator, I would like to leave with just one primary point. This is not a usual time. This field now has a critical window in which increased support out of the usual ordinary of inflationary increases can truly make an enormous difference.

At this time the field has unique opportunities, which can be realized if there is adequate support. The suggested research budget by the President calls for a $42 million reduction in ADAMHA research.

We call for a $151 million increase. That is more than an inflationary increase, but it is finally a substantial increase in this agency which has not had it for its research for some time.

It allows the possibility of realizing Dr. Thomas' forecast for the next decade. I believe we have an opportunity to turn the corner on mental illness over the next decade or two.

I have always been gratified and appreciative of this committee's farsightedness and support, and we ask you again to come to our aid and give us the opportunity to make this a full-fledged attack on these diseases.

PREPARED STATEMENT

Senator DOMENICI. Thank you very much, Doctor. Your written testimony will be made a part of the record.

[The statement follows:]

STATEMENT OF DR. HERBERT PARDES

Mr. Chairman and Members of the Subcommittee, I am Dr. Herbert Pardes, Vice President of the American Psychiatric Association, a medical specialty society representing over 33,000 physicians nationwide and Director of the New York State Psychiatric Institute. I testify in support of a major funding increase for the ADAMHA agency not only on behalf of the APA, but also on behalf of the American Association of Chairmen of Departments of Psychiatry, the American Association of Directors of Psychiatry Residency Training, and the American Society of Adolescent Psychiatry. The magnitude of ADAMHA's mission is evidenced by the following incidence statistics:

** At any given time, between 30-45 million people are suffering from some form of mental illness that requires professional treatment: an estimated 18 million adults over the age of 18 are alcoholics or problem drinkers; 12 million children suffer from autism, depression and other diseases which, left untreated, severely affect normal development and an estimated 60,000 children as young as 12 have tried cocaine; 1.5 million Americans suffer from the schizophrenias (with 300,000 new cases each year) and patients with schizophrenic disorders occupy over half of the hospitals beds for mentally ill or retarded individuals, and one quarter of all hospital beds in the U.S.; 9 million Americans have manic-depression, depression and/or depressive disorders; nearly one-fourth of the elderly who are diagnosed as "senile," actually suffer from a mental illness that can be treated effectively.

This is the stark picture against which the Administration's budget proposals must be viewed. Tragically, our national research investment, while on the order of $300 per person with cancer, is only $7 for every person with schizophrenia. The federal commitment, as portrayed in this budget, to lower this economic and social burden -- $250 billion of direct and indirect costs associated with mental illness and substance abuse disorders -- is woefully inadequate. The professional and citizen community has been incited to chart a different fiscal course and I submit for the hearing record a one page summary of this alternate plan for inclusion at the end of my prepared remarks.

Research

The Administration's ADAMHA research budget proposal of $410 million does not even remotely approach the FY 1988 current services or "no growth" benchmark of $553 million and falls woefully short of our suggested professional judgement alternative investment of $600 million. These proposed reductions would virtually strangle important fields of research and foreclose the implementation of important Congressional research initiatives in such areas as the schizophrenias, affective disorders, Alzheimer's Disease, chronic alcoholism and drug abuse. The budget also proposes to allocate research and treatment funds authorized under the recent Anti-Drug Abuse Act over a two-year period and to "carry over" $5 million in FY 1987 research funds into FY 1988 without regard to the appropriations process. Fortunately, these two proposals have been rejected in the context of the House-passed Supplemental Appropriation Bill and it is our hope that the Senate will take similar corrective action.

Mr. Chairman, as you know, the research supported by ADAMHA continues to merit the highest praise in the scientific community as it consistently yields important new clues to the diagnosis and treatment of serious mental and addictive disorders -- clues which we hope in time will yield cost-savings far in excess of this initial modest investment. As a recent front-page Washington Post article and last week's Newsweek cover story describe, NIMH-funded researchers have reported the identification of a specific gene as a cause of manic-depressive illness. Separate teams have identified a protein that appears to be specific to the brains of patients with Alzheimer's Disease, a finding which significantly enhances prospects for the development of a definitive diagnostic test for this disease. As I stated in a recent interview, these findings, "herald a new era in the application of genetics to psychiatric disorders" and will help patients and others understand that mental illness is not a problem of will or a failure of self-control, but a medical condition like heart disease or high blood pressure. It is our hope and expectation that a substantial boost in funding for the national research effort will yield further substantial dividends. Many of these are outlined in a new brochure entitled "On the Threshold of Discovery" for which I request inclusion in the hearing record.

Mr. Chairman, allow us to build on this identification of a gene associated with manic depressive illness; broaden the search for genetic factors in other mental illnesses such as schizophrenia; pursue the development of additional diagnostic tests and effective treatments for Alzheimer's disease; identify physiological and biochemical markers of genetic susceptibility to alcoholism; utilize brain imaging and neurochemical techniques; develop more effective methods for treatment of cocaine and other drug dependence; and develop new medications which will effectively treat mental illnesses, eliminate adverse side-effects, and reduce the number of non-respondents to current treatments.

I would like to make two additional points at this time. First, we request your favorable consideration of a stable, long-term commitment toward the development of both the infrastructure and expert manpower needed to promote scientific research of the scale and scope necessary to meet the challenge of schizophrenia. We want you to know that this particular focus on one illness can provide the underpinning for a future advance in our understanding of another illness. This is particularly relevant in the field of schizophrenia research which, in one important phase of its development, has benefitted from pursuing conceptual models and methodologies which evolved out of research on affective disorders. While we have tried to anticipate initial funding requirements -- we feel it important that this initiative not be mounted by reducing support or orderly growth in other areas of research or across certain research "mechanisms."

Second, I would like to specifically call to your attention one mechanism, Clinical Research Centers. As you know, new centers in the area of schizophrenic disorders will "come on board" this year. Through the provision of "core facilities" to support several research projects which are funded through separate Federal, State and private sources, the program enhances the national research effort by serving the needs of several individual research projects, with enhanced economy, efficiency, and consistency of results. In contrast to the President, we request funding of 10 new NIMH Centers and one new NIAAA Center in FY 1988.

Research Training

While we are pleased that the Administration has proposed a slight increase for ADAMHA research training, from $23 million in FY 1987 to a proposed $25 million for FY 1988, it is clearly not enough to remedy the consistent decline in mental health research training funds over the past several years. We feel that an appropriation of $32 million would allow the ADAMHA to better meet the biomedical, clinical, and behavioral goals of the Institute of Medicine with increased resources directed toward increasing the suprisingly small number of child psychiatrists and other childhood mental health professionals who are trained to conduct research. Without regard to the specific levels of dollars available for overall research training, support for the development of talented psychiatric researchers clearly has been disproportionate to the needs of the field. While the Institute of Medicine has recommended that the number of physicians supported by NIMH research training should approach 300 by the year 1990, NIMH has stated that in 1985, of the 996 trainees supported by NIMH research training funds, only 69 were psychiatrists. Our recommendation for the research training line item would support 1,200 trainees at the NIMH, 140 at NIDA and 203 at the NIAAA, enabling the Institutes to better meet the training targets recommended by the IOM.

Clinical Training

The Administration's FY1988 budget for NIMH Clinical Training departs from precedent and proposes $5 million, the first budget request for this program in six years. Although you have consistently rejected efforts to eliminate all funding, the funding for clinical training has declined drastically from a high of $93 million in FY 1969 to only $15 million in this fiscal year. The corresponding allocations for training in psychiatry have plummeted from $46 million to less than $6 million.

Despite the reductions over time, you should know, Mr. Chairman, that this program continues to be a major source of training support for psychiatry and other mental health professions. In this context, the most urgent need of psychiatric education centers continues to be funds to supplement teaching costs, i.e., to free up physician faculty from other income-producing duties so that they may concentrate more time in direct teaching and supervision of postgraduate house staff (not only psychiatric residents but also, through consultation-liaison programs, residents in the primary care disciplines) with respect to Congressional priority subject matter areas. Because other disciplines require different types of Federal assistance to meet training goals, we feel that appropriate flexibility in the use of Federal training funds is necessary. We believe that increasing program funding to $26 million will put the program back on track toward better meeting these important Congressional goals and priorities. To assure the expansion of systematic integration of substance abuse information into the core curriculum of health professional education we propose $1.0 million apiece -- under separate line items for NIAAA and NIDA Clinical Training -- to support alcohol and drug abuse education.

Other ADAMHA Activities

In response to time and length constraints and knowing many other witnesses will address the other areas of mutual interest and concern, I will not detail our support for the vital national activities outside of the research and training domain, which distinguishes ADAMHA from its "sister" agency -- The National Institutes of Health (NIH). Suffice to say, we support funding at maximum allowable levels for (i) the Alcohol, Drug Abuse and Mental Health Block Grant, (ii) the Community Support Program and Services Demonstrations, (iii) State Comprehensive Mental Health Services Plans, (iv) Protection and Advocacy and (v) the new Office of Substance Abuse Prevention.

Summary

Mr. Chairman, the alternative proposal I have outlined is both scientifically and politically justifiable. We are confident, Mr. Chairman, that with your support enhanced funding of ADAMHA activities will continue to yield dividends.

ADAMHA
(in millions)

	FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
RESEARCH				
NIMH	$249	$288	$235	$330*
NIDA	132	183	106	183*
NIAAA	71	82	69	90*
RESEARCH TRAINING	23	N/A	25	32
CLINICAL TRAINING	15	N/A	5	28
ADM BLOCK GRANT	509	530	495	650
SUPPLEMENTAL TREATMENT GRANTS	163	170	-0-	195
SERVICES DEMONSTRATIONS	15	N/A	20	24
PROTECTION/ ADVOCACY	10.5	11.0	7.0	11.0
STATE PLANS	N/A	N/A	-0-	10
OFFICE OF SUBSTANCE ABUSE PREVENTION	41.5	N/A	11.2	65.0
DIRECT OPERATIONS	60.3	65.4	60.9	77.1

(* includes AIDS recommendations)

Senator DOMENICI. I am aware of the evolution of the plan to attack schizophrenia through a comprehensive research program. I understand that the first assessments are that it could easily use $90 million in its program.

It has not been totally cleared yet through all of the various advisory sources, but I assume that will occur in the not too distant future and we will have that available up here.

I am not sure we can do that much all in one injection, but rest assured that there a number of us who understand that we must proceed in that area, in basic research on mental illness.

We are going to try and increase it substantially each year but make a commitment that it will continue with a degree of continuity that will attract the best and permit us to buy the best equipment at our universities and medical schools and laboratories.

We know of your excellent work when you were in the public sector and your continued interest, not only because of your involvement in the profession, but because of your background, is greatly appreciated. And we thank you for coming today.

Dr. PARDES. Thank you very much, Senator.

STATEMENT OF DR. LYNN P. REHM, PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF HOUSTON, AND CHAIR, COUNCIL OF UNIVERSITY DIRECTORS OF CLINICAL PSYCHOLOGY

Senator DOMENICI. I am going to have to go vote when the next lights go on there, but we will have time I think for one additional witness, perhaps two.

Dr. Rehm, Council of University Directors of Clinical Psychology at the University of Houston, chairman of that. And executive director Karst J. Besteman, Alcohol, Drug Problems Association of North America.

Why don't the two of you take seats here and if you follow each other, we might get you both in before I have to leave.

Dr. REHM. Thank you. My name is Lynn Rehm, and I am chair of the Council of University Directors of Clinical Psychology.

Senator DOMENICI. Excuse me for mispronouncing your name.

Dr. REHM. That is quite all right. The council is made up of directors of 135 of the Nation's university-based doctoral training programs in clinical psychology.

I would like to take this opportunity to comment on the graduate training components of the NIMH budget for fiscal year 1988. To summarize very briefly my written testimony, there are four points that I would like to make.

First, we strongly support the clinical training budget for NIMH at the level of $26 million for fiscal year 1988. I would also like to add at this point that we would also strongly support the clinical training funds which are currently in the House version of the supplemental budget for fiscal year 1987.

Second I would like to urge Congress to continue to support the statutory payback provision of the clinical training program, requiring trainees who receive stipends for graduate training to repay this direct support through service delivery in a mental health shortage area, or within an underserved population.

Third, the council concurs with last year's House and Senate Appropriations Committee reports which emphasized the committee's continued commitment to the State Manpower Development Program and the Minority Fellowship Program.

This program has proved to be a wise investment. There continues to be a great shortage of qualified minority mental health professionals in the country.

My fourth point is that our council would like support of research training as well in the NIMH budget, at a level of $26 million and the $330 million for research.

In my remaining time I would like to give you just a personal comment on what I believe has been the effectiveness of the clinical training grants program. We at the University of Houston have had from 1983 to 1986 had a clinical training grant involving children and families in urban mental health systems.

One component of this program was setting up a specialized practicum for graduate students in clinical psychology, with the cooperation of the Houston Child Guidance Center at the Chimney Rock Center in Houston.

The Chimney Rock Center is a facility which sees court-referred children and their families, the population is largely inner-city, minority, broken homes, and complex problems involving mental health, welfare and court systems.

Our graduate students here are involved in evaluating and doing crisis intervention with these children and their families, and doing interdisciplinary consultation within these various systems. This has been an excellent, intense, and unique experience for these students.

PREPARED STATEMENT

Senator DOMENICI. Doctor, I am sorry. We are going to have to cut you short. We will put your testimony in the record.

[The statement follows:]

STATEMENT OF DR. LYNN P. REHM

Mr. Chairman and Members of the Committee, I appreciate this opportunity to present testimony on the subject of Fiscal Year 1988 appropriations for the National Institute of Mental Health (NIMH) Clinical Training program. I am Dr. Lynn Rehm, a clinical psychologist serving on the faculty of the University of Houston, as well as engaged in private practice, and am serving this year as Chair of the Council of University Directors of Clinical Psychology. The Council represents over 80 percent of the approximately 170 clinical psychology programs in the United States, and has been in existence for over two decades. The NIMH clinical training program plays a key role in the training of clinical psychologists by providing both direct and institutional support to many of our nation's programs. I welcome this opportunity to share the Council's views on this important NIMH program.

NIMH Clinical Training Program

The Council strongly supports funding for the NIMH Clinical Training program at $26 million for FY 1988. NIMH provides the major source of the nation's mental health clinical training funds. The program has supported thousands of trainees in psychology and the other three core mental health professions -- psychiatry, social work, and nursing -- in every state. NIMH currently supports over 200 clinical training programs such as those at Florida A&M, Children's Hospital in Boston, Yale University, Michigan State University, UCLA, The Houston Child Guidance Center, University of Maryland, University of Minnesota, University of Hawaii, New Mexico State University, the Morrison Center for Youth and Family Service in Portland, Oregon, Pennsylvania State University, and Medical University in Charleston, South Carolina. But because of the budget cuts that have already occurred, 42 of these grants are slated for termination this year.

While the Administration has persistently sought to eliminate the clinical training program over the past five years, Congress has consistently rejected these proposals. The Administration has argued that over the years since the inception of the clinical training program the number of mental health professionals has significantly increased. While this statement is true, there continue to be many underserved populations and geographic areas, and a shortage of qualified minority mental health professionals, in particular. In preserving this program, Congress has emphasized the value of ensuring "that professionals are given the skills required to appropriately serve high-priority populations" and underserved individuals, such as seriously mentally disabled children and adults, the homeless, the elderly, and those in rural areas. In addition to the actual service that trainees provide, the clinical training program acts as a catalyst for developing curricula and specialized training for students before they go into these priority areas. Thus, thanks to NIMH support, these programs in your home states and Congressional districts are developing state-of-the-art knowledge about the underserved populations and areas which Congress has instructed them to serve.

The "Payback" Obligation

We also urge Congress' continued support for the statutory "payback" provision of the clinical training program requiring all trainees in psychology, psychiatry, social work, or nursing who receive stipends for graduate training for a period of 180 days or more to repay this direct support through service delivery in a mental health shortage area or with an underserved population. Given prevailing fiscal restraints, APA recommends mandating that a fixed minimum percentage of clinical training funds awarded to each profession -- such as 50 percent -- be linked to the services payback requirement. Such a mandate would ensure that taxpayers receive the maximum return on their investment in this program: mental health care for those in special need, and the foundation for continued specialized, state-of-the-art training to serve special populations.

To ensure further the accountability of the clinical training program, APA also recommends equitable distribution of program funds among the four core mental health professions. At the present time, the three mental health professions that receive more than 50 percent of their funds under the payback obligation (psychology receives 88 percent of its funds, social work 66%, and nursing 52%, in this manner) receive 59 percent of the funds combined. Psychiatry, on the other hand, receives a full 40 percent of the total allocation yet only 7 percent of these funds are used for direct support for graduate training for a period in excess of 180 days, and therefore do not incur the payback obligation. Thus, equitable distribution, and perhaps an increase in the 180-day limit, would result in a greater return for each dollar invested.

State Manpower Development and Minority Fellowship Programs

Finally, the Council concurs with last year's House and Senate Appropriations Committee reports which emphasize the Committees' continued commitment to the State Manpower Development Program and the Minority Fellowship Program (MFP). The Committee Reports specifically credited the State Manpower Development Program with having demonstrated its value in addressing target populations, such as those who are seriously mentally disabled, which would not otherwise be served. In 1974 NIMH began jointly funding the Minority Fellowship Program in Psychology with the American Psychological Association. Fellowships are granted under a cost-sharing arrangement with graduate departments to cover tuition, books, and other related expenses. Under the MFP, well over 300 Blacks, Hispanics, Native Americans, Asians, and Pacific Islanders have been trained to provide direct mental health services. The program has proved to be a wise investment. By its use of cost-sharing measures, the program has been able to support at least twice as many students as it would have otherwise. Yet even with the MFP's excellent record of increasing the number of minority mental health professionals in all disciplines, data on earned doctorates in clinical and counseling psychology indicate that less than nine percent of the degrees awarded in 1985 were to minority students. Clearly, there continues to be a shortage of qualified minority mental health professionals in this country. be served.

Thank you, again, for this opportunity to testify on behalf of the Council of University Directors of Clinical Psychology. If I may be of any further assistance to you, please don't hesitate to call on me.

Senator DOMENICI. I am going to have to recess until I return from this vote, or the chairman returns, whichever is the soonest.

[A brief recess was taken.]

STATEMENT OF KARST J. BESTEMAN, EXECUTIVE DIRECTOR, ALCOHOL & DRUG PROBLEMS ASSOCIATION

Senator DOMENICI. Mr. Besteman, you may proceed.

Mr. BESTEMAN. Thank you, Mr. Chairman. Iappreciate this opportunity to represent the Alcohol & Drug Problems Association before you.

We represent the broadest coalition in the field from State governments through individuals, State associations, and private, nonprofit and for-profit treatment and prevention agencies.

We are here in support of appropriations for NIDA, NIAAA, and the ADAMHA block grant, because as consumers of products which the two institutes produce, we are dependent on them to settle major issues for us and give us guidance in our work.

We are particularly eager to have the institutes look at treatment evaluation, prevention evaluation, and to study new treatment modalities, particularly as it relates to the cocaine and alcohol combination, which is plaguing our treatment agencies right now.

We also would urge that the two institutes be given adequate appropriations, and in my testimony I outline the precise numbers that go into the various categories, and it will be in the record, because we feel there is a great need for expanded data collection, particularly in epidemiology, in survey work, and in order to use that data in policy and program guidance.

The administration in the proposal that they put for the fiscal year 1988 budget, I believe and our association believes, reneged on an important initiative and commitment that the Congress and the administration made together last year.

And we would like to see that action corrected and that at a minimum, particularly the treatment initiatives be sustained. The block grant and the initiative represent somewhere around 18 percent of the resources used to treat addicts and alcoholics in this country and is sufficiently large so that if that area is withdrawn we are then going to suffer from not having even sustained what was a very hopeful initiative of last fall.

PREPARED STATEMENT

I thank you for the opportunity to appear here, and I will leave the green light on and we will get on our way. Thank you, Mr. Chairman.

Senator DOMENICI. Thank you. You do not know, you might get favored treatment. [Laughter.]

Mr. BESTEMAN. That is what I am angling for. I want points. [Laughter.]

[The statement follows:]

STATEMENT OF KARST J. BESTEMAN

I want to thank you and members of the committee for the opportunity to testify on behalf of the Alcohol and Drug Problems Association. ADPA is the most diverse and experienced professional association in the field having been organized in 1949. It is made up of four constituent councils. There is the Council of State Agencies, the Council of Agencies (public, private, profit and non-profit), the Council of Individuals, and the Council of State Associations. We are united in the task of formulating public policy, enhancing the quality of services provided and solving the problem of alcohol and drug abuse.

During the last Congress important initiatives to reduce the demand for drugs were authorized and funded. The Administration in proposing the FY 1988 budget has recommended that these significant and much needed actions be severely reduced or eliminated. It is our opinion that complying with the Presidents request would not be in the best of the health and safety of the American people.

Abandoning the first substantial increase in drug abuse treatment services in a decade and withdrawing from the first ever federal drug and alcohol prevention funding is detrimental to the goal of reducing drug abuse to pre-epidemic levels and conflicts with the Administration's state goal of a drug free school and work-place.

The treatment providers of the country are watching carefully the actions of this committee. Expanding the treatment system nationally as intended by last fall's legislation takes several months. Local treatment programs are loath to leap into an expansion effort if from the outset there is no intention of sustaining the effort. Because treatment is labor intensive, and a skilled, committed, and talented person is needed to work with the patients treatment system sare unable to expand and contract rapidly. Truly patient lives are at stake. We strongly urge the committee to sustain the funding in the ADM Block grant and in the 1986 Anti-Drug initiative which provided a critical and well justified increase in treatment services.

The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism are also very important to the service community and the public. Both Institutes serve the country by selecting and supporting key basic and applied research. The fundings guide policy and practice by professionals across the country. We would urge a funding level of 183 million for NIDA and 89.5 million for NIAAA. These levels would sustain NIDA's quickened activity level resulting from last year's initiative and enable NIAAA to expand its research into much needed areas as the impact of alcohol abuse among the aging.

There is justification for expansion of the Institutes efforts beyond even these levels. There are large gaps in our knowledge base on the immediate negative effects and long term consequences of illicit drug abuse. The nations survey capacity and data base in epidemiology has eroded since the 1970's and for the development of effective policy it must be restored. Treatment outcome and evaluation continues to be a high research priority. In the demand reduction activity this is the largest expenditure. Well designed research can given us guidance in spending the approximately 1.3 billion dollars of local, state and federal funds. Compared to the immense social costs directly attributed to alcoholism and drug abuse our research expenditures are not adequate.

The action we request of this committee is to sustain the modest goals of 1986 and to insure by increasing research funds that alcohol and drug problems will be solved based on knowledge. For the last thirty years interest by the public, attention by the media, and funding by the Congress has waxed and waned. Alcohol and drug problems have reshaped and sustained themselves causing many casualties. There are signs of progress and improvement. This is the time to commit to sustained effort.

Alcoholism and drug abuse are expensive to our society. Left unattended these conditions spread and the numbers of sufferers increases. Comprehensive efforts to address these issues demonstrate that this disease is preventable and treatable. Recovery and sobriety are achieved by thousands of people each year as a result of the federal investment in prevention, treatment, and research. I urge the committee to restore the omissions of the Administration's proposals and signal the country that there is the will and the resources to build on the progress which was achieved with such great effort.

Thank you Mr. Chairman for the privilege of appearing before your committee. Members of my Association and I are ready and eager to assist the Committee by answering questions or supplying information.

Senator DOMENICI. Let us get the next two witnesses to come on up to the table.

Dr. Erickson, College of Pharmacy, University of Texas, and John S. Gustafson, National Association of State Alcohol and Drug Abuse Directors.

STATEMENT OF DR. CARLTON K. ERICKSON, COLLEGE OF PHARMACY, UNIVERSITY OF TEXAS

Dr. ERICKSON. I am Dr. Carl Erickson, professor of pharmacology and head of the Alcohol and Drug Abuse Research Program at the University of Texas at Austin. I am also a member of the Research Society on Alcoholism.

I consider myself an active scientist in the field. My own research concerns the effects of alcohol on the chemistry of the brain and on the interactions between alcohol and aging.

And I believe given enough funds, scientists like myself will be able to make a significant impact on the suffering of the elderly and the children of alcoholics in the future.

Senator DOMENICI. Doctor, I have an urgent call. I must go make it right now. The motion to waive the Budget Act, to take up the supplemental failed. So it means we do not have a supplemental. Let me call our leader, and see what he wants.

In the meantime I was going to ask you, is Texas still paying its professors? Do you all have enough money? [Laughter.]

Dr. ERICKSON. I will find out when I get home. [Laughter.]

Senator DOMENICI. Did you get your last check? [Laughter.]

Dr. ERICKSON. Yes.

Senator DOMENICI. All right. We will proceed. I do not know if this machine is capable of that interruption, so we will start over. We will just estimate when you have completed 2 minutes or the red light, whichever. Go ahead, doctor.

Dr. ERICKSON. Thank you. I was in the process of telling you about my research and I think I finished with that.

Now I will continue to say, I am convinced that alcoholism is a disease that is beyond the control of the victim, and that alcoholism is not a moral weakness anymore than syphilis, polio, or diabetes.

I am not an alcoholic but I have worked with recovering alcoholics and their families and I know what a devastating disease it can be, especially for the children of alcoholics. I fear that someday it may strike me or several of my family and friends.

This is a legitimate fear for we know that 1 in 10 consumers of alcohol are susceptible to the disease of alcoholism. As a researcher in the field for 20 years I have been following the budget of the National Institute on Alcohol Abuse and Alcoholism since it was formed in 1970.

Although the present fiscal year 1987 budget is 2½ times what it was in 1979, the number of dollars being spent on research in this field is only a little more than 1 percent of all the Federal dollars that are allocated to research on all other diseases.

This is to put it mildly unbelievable, when we consider that alcoholism is among the top three diseases in the United States in terms of death and incidence, and that the cost to our society of alcoholism and drug problems is over $130 billion a year.

I just do not understand how we can sit back and let people die from alcoholism, when we have it within our power to find the causes of this disease through research, if scientists only had enough money to work with.

For fiscal year 1988 President Reagan has recommended that we cut back the number of new and competing research grants in NIAAA from 117 per year to 89 per year. This cannot be progress.

What that will mean is that fewer good scientists will be attracted into the laboratories to work on the causes and consequences of alcoholism. I realize the need to reduce spending and to reduce the national deficit and to balance the budget.

But we must maintain even the modest gains that NIAAA and other ADAMHA institutes have made in the past, so that people affected by alcoholism and other drug problems can have some hope for the future.

I therefore recommend that Congress allocate an amount of $89.5 million for intramural and extramural NIAAA research, $4.4 million and $13.2 million for research training and program support, respectively, $3 million for the homeless initiative, and $7 million for building and facilities for a total of $111.4 million for the institute.

Much more money is actually needed for scientists to make progress in this area. But this is the professional judgment request of the Research Society on Alcoholism.

PREPARED STATEMENT

And Senator, this is not the first time that I have appeared before this subcommittee, but if the subcommittee does not mind each year that I request to come back I am going to continue to try to appear before you until this disease receives the money that it needs so desperately.

[The statement follows:]

STATEMENT OF DR. CARLTON K. ERICKSON

My name is Dr. Carlton Erickson, and I am Professor and Head of the Division of Pharmacology and Toxicology at the University of Texas at Austin. I am also Head of the Alcohol and Drug Abuse Research Program at the University, as well as Executive Director of the Texas Research Society on Alcoholism and a member of the national Research Society on Alcoholism. I have devoted my career to the study of drugs of abuse, and in particular, alcohol. My interest in alcohol arises not from any family or personal involvement with the disease of alcoholism, but from a scientific standpoint, since alcohol is one of our least understood drugs. How it acts on the brain to cause intoxication and disease is a cause of considerable curiosity and interest to me, and so I have been studying alcohol for about 20 years. I currently hold a research grant from NIAAA to study the neurochemistry of alcohol and aging in animals.

I began research on alcohol in 1967, when I was fortunate to receive a grant from the National Institute on Mental Health. Three years later, in 1970, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was formed, and funds began to be allocated specifically for alcohol problems. Over the years, the budget of NIAAA has grown slowly. There was even a period from 1979-1982 during which the research budget remained stable.

Today, I'd like to take just a few minutes of your time to discuss the budget of NIAAA. As you may recall, the 1980 and 1984 reports from the Institute of Medicine (IOM) recommended substantial increases in the research budget of NIAAA. Fifty percent annual increases for 3 years were suggested, beginning with the 1979 NIAAA budget of $22 million, and increases in constant 1983 dollars, to $100 million in FY 1985. We are now beyond that time period, and instead of $100 million, the research budget for NIAAA is only $71.2 million, following cuts caused by the Gramm-Rudman-Hollings Amendment. The total FY 1987 appropriations for NIAAA, including training and direct operations costs, is $84.3 million, following Gramm-Rudman. And now your Subcommittee is trying to decide whether to increase President Reagan's FY 1988 budget of $81.7 million, which is a 3% decrease over the FY 1987 revised budget for NIAAA.

I would like to emphasize the fact that the NIAAA budget did not escalate at the rate proposed by IOM from 1981-1985. Only in 1983 was the IOM recommendation followed by Congress. More importantly, the amount of funding devoted to research on alcoholism, the nation's number 2 disease, is only about 6% that allocated for cancer research (FY 1987 appropriations), 9% that allocated for heart, lung, and blood disorders, and less than the amounts allocated for dental research and aging research.

Obviously, the nation is caught in an embarrassing situation where it is only now beginning to recognize the seriousness of alcohol and other drug abuse problems and addictive diseases. Some people recognize how paultry the previous research support has been in these areas, and we are now trying to catch up and go ahead in a time of tight funding. Research on the causes and prevention of alcohol and other drug problems has been the victim of a late start (alcohol research is really only about 15-20 years old). In addition, the stigma associated with the disease of alcoholism, and inability of my colleagues and I to educate the public on what research can do to conquer alcoholism, has hurt us. Do you realize, for example, that scientists are now quite certain that many forms of alcoholism are passed from one generation to another, and that this disease is one that even social drinkers cannot escape? We are beginning to realize that most forms of alcoholism are caused by defects of brain or body chemistry, over which the victim has no control. Anyone who uses alcohol could become addicted at any time!

Let me tell you what I feel alcohol researchers will continue to do for the nation. I can see, for example, a diagnostic test for alcoholism within 5-10 years. I can see, in the next 10-15 years, better prevention methodologies, based upon an increased knowledge of the genetics of alcoholism. I can see, in 15-20 years, better and more cost-effective treatments, based upon increased knowledge of the causes of alcoholism. I foresee less suffering by elderly alcoholics, based upon future progress in this area. And I can see, in 15-20 years, a greatly reduced incidence of the disease, which has remained steady at 5% of the population for the past 5 years. These milestones can be achieved, but only if funding for alcohol research is greatly increased this year and every year thereafter.

Some people may believe that alcoholism is already being adequately treated, and that there is little need for research. This is not true. The economic costs to society of alcohol problems continue to rise each year. In 1980 they were estimated at $48 billion. Estimates since then have been $60 billion and $78 billion, and recent estimates place the cost to society at over $120 billion! We must keep in mind that no disease has ever been conquered by only treating the victims. Research must find the causes - only then will the incidence and subsequent economic costs begin to decline.

Any business person realizes that long-term investments are a predictable way to gain significant payoffs in the future. If we commit ourselves to an investment into the causes of alcoholism, by increasing funds for research grants and the training of young scientists in this field, past experience tells us that this will certainly provide future advantages. Do you realize that the investment in cancer research is currently 3.3 cents for each dollar of the economic cost to society, while the investment in alcoholism research is only 4 hundredths of one cent for each dollar of cost?

In 1983 federal tax revenues from the sale of alcoholic beverages totalled $5.7 billion. One tenth of those revenues would have provided NIAAA with 20 times the research budget it had in 1983. Does it make sense to spend only $70 million per year on research into finding the causes and solutions to a disease that costs U.S. taxpayers over $100 billion per year? Do you realize that an investment in alcohol research now, in terms of a modest number of dollars compared to those being considered for U.S. defense, could save thousands of lives, perhaps those of some of your family or friends? Surely anyone can see that President Reagan's FY 1988 recommended budget for NIAAA is not indicative of a far-sighted investment. I am amazed, after the President's apparent recognition of the importance of conquering drug problems last year, that he would actually propose to reduce appropriations for this problem. One shot of penicillin does not cure syphilis, and one year's increase in research funds will not cure our nation's drug problems!

I am personally aware of several colleagues who have had grants reviewed by NIAAA, who have received excellent priority scores for projects which will not be funded due to insufficient funds. These scientists may soon get discouraged and turn to other intellectual pursuits. What disturbs me more than anything is that alcoholism, the fetal alcohol syndrome, DWI, child abuse, accidents, and other effects of alcohol abuse will never be conquered unless we can support the good scientists while attracting new ones into this area of research. Just as I was attracted to the field in 1967, we now need to attract more scientists to work on this enormous problem of drug abuse which affects us all. Unless immediate and reasonable research and training funds are forthcoming, we are only going to slide backwards in our goal of conquering these problems.

Members of the subcommittee, for the past 8 years I have worked diligently to increase funds for alcoholism research in Texas, through state, private and public sources. I know that individuals, foundations and state governments cannot possibly supply enough money to scientists to make a significant dent in the armor which surrounds the mystery of alcoholism. The federal government simply has to take the lead in the conquest of alcohol problems, because only a major committment to reducing these problems will pay dividends. I realize you want to reduce the budget deficit, that other special interest groups are tugging at the purse strings. But, we have waited long enough. I urge you to significantly increase the funds for alcohol research and training, and for other ADAMHA programs which are interfaced with alcohol problems. I urge that you allocate an amount of $89.5 million for intramural and extramural NIAAA research; $4.4 and $13.2 million for research training and program support, respectively; $3 million for the homeless initiative; and $.7 million for building and facilities. This adds up to a total of $111.4 million for the Institute. Another $4.8 million for AIDs-related research to study alcohol-related immunologic deficits would also be appreciated, since it appears that alcoholism can significantly affect the course of this modern-day plague.

Please don't wait until alcoholism strikes you or a member of your family before you become emotionally involved in these problems.

STATEMENT OF JOHN S. GUSTAFSON, DEPUTY DIRECTOR, DIVISION OF SUBSTANCE ABUSE SERVICES, STATE OF NEW YORK, AND VICE PRESIDENT FOR DRUG ABUSE ISSUES, NATIONAL ASSOCIATION OF STATE ALCOHOL & DRUG ABUSE DIRECTORS

Mr. GUSTAFSON. My name is John Gustafson, deputy director of the Division of Substance Abuse Services of the State of New York, and I am appearing before you today representing as vice president for drug abuse issues the National Association of State Alcohol & Drug Abuse Directors. NASADAD is the acronym.

Before I begin our statement, I wish to express our sincere appreciation and recognition of your long-standing support for the Federal alcohol and drug abuse programs, and more recently your leadership in securing passage and funding for the Anti-Drug Abuse Act of 1986.

The health and social consequences of drug and alcohol abuse are severe and complex. Almost one-third of our college students have used cocaine. A minimum of 60 percent of pediatric AIDS cases are related to intravenous drug use by one or both parents.

Alcohol is the third leading cause of birth defects with accompanying mental retardation, and the only one that is preventable. At least 30 percent of our homeless population have a serious alcohol or other drug abuse problem which requires treatment.

In fiscal year 1986 $1.6 billion was expended for publicly funded drug and alcohol treatment and prevention services. States provided over one half of these resources. The Federal Government less than 20 percent.

Exhibit A included in my written statement provides a comparison of Federal appropriations for alcohol and drug treatment and prevention services from fiscal year 1980 to fiscal year 1987. The comparison demonstrates significant reductions in Federal support.

Last year when the Anti-Drug Abuse Act authorized a supplemental emergency grant program for treatment services, the State and local providers were extremely pleased with the prospect for increased Federal support.

Our pleasure was very shortlived, however, when the president did not request any new moneys in the fiscal year 1988 for continuation of the Federal Government's renewed commitment to the treating of alcohol and drug abuse.

What is even more perplexing is that the President has proposed that the $163 million appropriated for fiscal year 1987 supplemental emergency grant program be awarded to the States to cover both fiscal year 1987 and fiscal year 1988, effectively halving the utility of those funds.

The Alcohol, Drug Abuse and Mental Health Services Block Grant Program, which is the primary source of Federal support for drug and alcohol treatment services was also reduced in the President's budget from $509 million in fiscal year 1987 to $495 million in fiscal year 1988.

As I am sure you are aware, renewal of the ADMS block grant will be considered by Congress this year. NASADAD will be advocating for a 3-year reauthorization of this important service program and a consolidation of the newly authorized supplemental alcohol and drug treatment grants into the alcohol and drug portion of the ADMS block grant.

The authorization levels which we will be proposing will reflect this consolidation of treatment grants and a 20-percent growth in the program. The proposed authorization level for fiscal year 1988 is $806 million.

We respectfully request that the members of the Appropriations Committee seriously consider appropriating the full amount authorized for these programs in fiscal year 1988.

PREPARED STATEMENT

Your visible commitment to reducing the unmet demand for treatment services and providing relief to treatment providers must be continued by renewing your support for both the ADMS block grant and the Emergency Supplemental Grant Program. Thank you for the opportunity to appear before you today.

Senator DOMENICI. Thank you very much, Mr. Gustafson.

[The statement follows:]

STATEMENT OF JOHN S. GUSTAFSON

Thank you for the invitation to appear before you today to address the President's FY 1988 Budget Request for Federal Alcohol and Drug Abuse Programs.

My name is John Gustafson. I am a Deputy Director for the New York State Division of Substance Abuse Services and am appearing before you today as the Vice President for Drug Abuse Issues of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). NASADAD is a not-for-profit organization whose membership is exclusively comprised of the State officials designated by the Governors to administer the publicly-funded drug and alcohol treatment and prevention system.

Before I begin our statement, I wish to express our sincere appreciation and recognition of your longstanding support for the Federal alcohol and drug abuse programs and, more recently, your leadership in securing passage and funding for the Anti-Drug Abuse Act of 1986, P.L. 99-570.

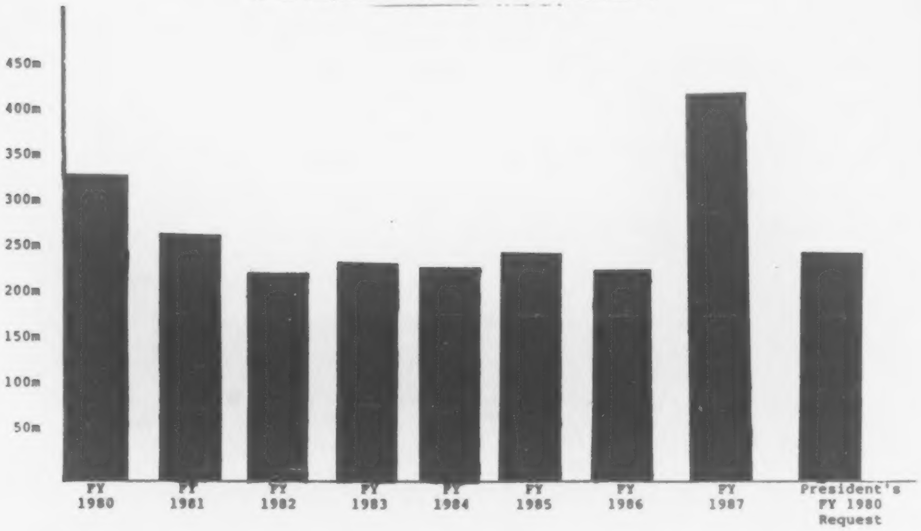
Mr. Chairman, the health and social consequences of drug and alcohol abuse are severe and complex. The economic costs of these diseases to society in the year 1983 alone were $176 billion. Almost one-third of our college students have used cocaine. A minimum of 60% of pediatric AIDS cases are related to intravenous drug use by one or both of the parents. Alcohol is the third leading cause of birth defects with accompanying mental retardation and the only one that is preventable. At least 30 percent of our homeless population have a serious alcohol or other drug abuse problem which requires treatment. Clearly, these illnesses are having a major, catastrophic effect on the health and welfare of our nation.

In FY 1986, $1.6 billion were expended for publicly funded drug and alcohol treatment and prevention services. States provided over one-half of these resources, the Federal government less than 20 percent. Exhibit A included with my written statement provides a comparison of Federal appropriations for alcohol and drug treatment and prevention services from FY 1980 to FY 1987. This comparison demonstrates significant reductions in Federal support from FY 1980 to FY 1986. Only in FY 1987 is an increase in support documented. However, if the President's request for these programs for FY 1988 is agreed to by the U.S. Congress, the level of fiscal support for the Federal programs will fall below the FY 1980 level of support.

EXHIBIT A

Comparison of Federal Appropriations for
Alcohol and Drug Treatment Services
From FY 1980 to FY 1988

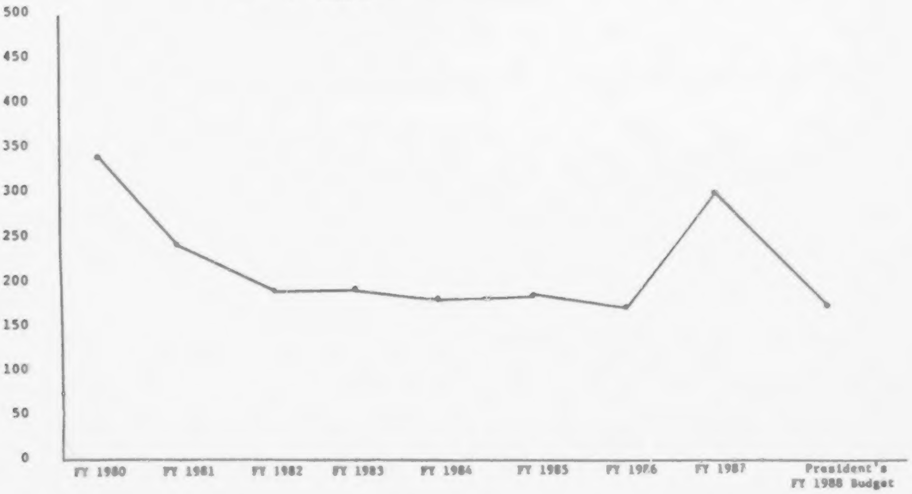
($ in 100,000 and not adjusted for inflation)



When the level of Federal support for alcohol and drug treatment and prevention services is adjusted for inflation, as displayed in Exhibit B of my written statement, it is discouraging to note that even the FY 1987 level of support is clearly below the level of Federal monies needed to maintain the level of services supported by the Federal government seven years ago.

EXHIBIT B

Comparison of Federal Support
for Drug and Alcohol Treatment
Services in Selected Years
and Adjusted for Inflation*



* Based on official CPI estimate from Department of Labor through 1986; projected 3% CPI for FYs 1987 and 1988

Last year, when the Anti-Drug Abuse Act authorized a supplemental, emergency grant program for treatment services, the State and local providers were extremely pleased with the prospect of increased Federal support. Our pleasure was short-lived, however, when the President did not request any new monies in FY 1988 for continuation of the Federal Government's renewed commitment to treating alcohol and drug abuse. What is even more perplexing is that the President has proposed that the $163 million appropriated for the FY 1987 supplemental, emergency grant program be awarded by the States to cover both FY 1987 and FY 1988. A State's ability to meet the needs which are to be addressed by this emergency program are being further hampered by the fact that we have only received one-half of the emergency monies to be allocated based on population, approximately $73 million, and just received notice of the application process for the remaining $90 million in emergency funds. All of these monies were required by statute to be made available to the States no later than mid-February of this year.

The Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant program, which is the primary source of Federal support for drug and alcohol treatment services, was also reduced in the President's budget from $509 million in FY 1987 to $495 million for FY 1988. (Approximately 50% of the Block Grant monies are utilized for drug and alcohol treatment and prevention services.) As you are probably aware, renewal of the ADMS Block Grant will be considered by the Congress this year. NASADAD will be advocating for a three-year reauthorization of this important service program and a consolidation of the newly authorized supplemental alcohol and drug treatment grants into the alcohol and drug portion of the ADMS Block Grant. The authorization levels which we will be proposing will reflect this consolidation of the treatment grants and a 20 percent growth in the program. Specifically, the proposed authorization levels are $806 million for FY 1988; $967 million for FY 1989 and $1.1 billion for FY 1990. These programs - the ADMS Block Grant and the supplemental treatment grants - are currently receiving and appropriation of $672 million in FY 1987.

We respectfully request that the Members of the Appropriations Subcommittee seriously consider appropriating the full amount authorized for these programs for FY 1988. The ADMS Block Grant plays a critical role in the publicly-funded treatment and prevention system. Your visible commitment to reducing the unmet demand for treatment services and providing relief to treatment providers must also be continued by renewing your support for the emergency, supplemental grant program. One year of new monies for treatment services will not have a very effective or dramatic impact on our treatment system unless it is part of a long term program. These programs must be continued if we are going to significantly expand treatment capacity, increase outreach services and have a comprehensive approach towards reduction of these major public health problems.

State grant programs for drug abuse education and treatment for drug abusing offenders also fell victim to the budget ax. The new Department of Education initiative was reduced by 50% from $200 million in FY 1987 to $100 million in FY 1988. The Department of Justice grant program was less fortunate - the $225 million appropriated for FY 1987 was eliminated for FY 1988. Mr. Chairman, it is also of great concern to the treatment and prevention community, that the Administration declined to request any monies for the continuation of the new Office of Substance Abuse Prevention or the $20 million categorical grant program for the prevention and treatment of drug and alcohol abuse among high-risk youth. We respectfully request that the Chairman and Members of the Subcommittee consider full funding for these programs for FY 1988 as well as for the important Federal research programs being undertaken by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse.

Attachment 1 of our statement provides a detailed justification for our budget request and reflects a concensus of the alcohol, drug abuse and mental health communities.

Thank you for the opportunity to appear before you today.

ATTACHMENT 1

FISCAL YEAR 1988 COALITION APPROPRIATIONS RECOMMENDATIONS FOR ADAMHA

American Academy of Child and Adolescent Psychiatry
American Association for Counseling and Development
American Association for Marriage and Family Therapy
American Association for Partial Hospitalization
American Association of Chairman of Departments of Psychiatry

American Association of Directors of Psychiatric Residency Training
American College of Neuropsychopharmacology
American Council for Drug Education
American Hospital Association
American Medical Society on Alcoholism and Other Drug Dependencies
American Mental Health Counselors Association
American Psychiatric Association
American Psychological Association
American Rehabilitation Counseling Association
American Youth Work Center
Americans for Substance Abuse Prevention and Treatment
Association for Counselor Education and Supervision
Association for Specialists in Group Work
Association of Adult Development and Aging
Association of Labor-Management Administrators and Consultants on Alcoholism
Association of Mental Health Administrators
Association of Minority Health Professions Schools
CareInstitute
Committee on Problems of Drug Dependence
Corporation for the Advancement of Psychiatry
Families in Action National Drug Information Center
International Association of Psychosocial Rehabilitation Services
Legal Action Center
Mental Health Law Project
National Alliance for the Mentally Ill
National Association of Alcoholism Treatment Programs
National Association of Social Workers
National Association of Private Psychiatric Hospitals
National Association of Protection and Advocacy Systems, Inc.
National Association of State Alcohol and Drug Abuse Directors
National Association of State Mental Health Program Directors
National Council of Community Mental Health Centers
National Mental Health Consumers Association
National Mental Health Association
Northeastern Regional Methadone Treatment Coalition
Therapeutic Communities of America

OVERVIEW

This document reflects the views of a coalition of consumer, provider and citizen advocacy organizations deeply concerned with the inadequacy of the President's proposed fiscal year 1988 budget for people with mental disorders, alcoholism, and alcohol or drug abuse problems. We believe that funding for programs under the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) is now -- and has for some time been -- critically short of the need. This view is supported by the Institute of Medicine in its report "Research on Mental Illness and Addictive Disorders: Progress and Prospects":

> "Mental disorders and addictive states, especially when severe or chronic, cause personal, economic, and social upheaval both for afflicted individuals and for those close to them. In the United States alone, conservative estimates suggest that mental disorders and addictions directly afflict 30 to 45 million people and cost $20 billion annually in direct health-care expenditures. They contribute especially to morbidity, using such measures as utilization of long-term care and Social Security Disability, and the indirect costs to society, including lost productivity, social services, and crime control. Overall, yearly direct and indirect expenses total an estimated $185 billion. Costs are especially high for the severe mental problems of childhood, which can produce lifelong debilitation. These data suggest that the economic consequences of the disorders under the ADAMHA purview are comparable to those for heart disease and cancer."

We have reviewed the President's budget and are united in opposition to it.

The President's budget focuses on large reductions in many domestic spending programs, including those of vital importance to mentally disabled people and those addicted to alcohol and drugs. At best, programs are continued at current levels; at worst, they are callously eliminated. The President proposes reductions in research and research training, at a time in our history when a modest expansion in these areas is essential to capitalize on new knowledge about the brain and behavior. The budget seeks to circumvent the budget process and the recent HHS Appropriation Act by proposing to extend the availability of fiscal year 1987 research funds into fiscal year 1988. No growth is sought in service delivery activities, including those programs authorized by the historic Anti-Drug Act. An unjustified reduction is proposed for the new program of protection and advocacy services for mentally ill persons and for the NIMH Clinical Training Program. No funds are requested to implement a new state planning program. Staff support and direct operations activities are dangerously low.

While acknowledging the need to address budget deficits in light of the Gramm-Rudman-Hollings Balanced Budget Act, we do not believe human service programs, including those of ADMAHA, should bear the heavy burden of further cuts. These programs have been "pared to the bone" already, and Congress must look at alternative means to control the federal deficit.

Adoption of the recommendations on the following pages will enable the federal government to maintain a leadership role in support of ADM programs . . . Research, Services, Training and Planning. We urge the Congress to seriously consider our recommendations as the FY '88 appropriations process moves forward.

APPROPRIATIONS FISCAL YEAR 1988--ADAMHA

(in millions)

	FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
RESEARCH				
NIMH	$249	$288	$235	$330*
NIDA	132	183	106	183*
NIAAA	71.2	82.2	68.9	89.5*
RESEARCH TRAINING	23	N/A	25	32
CLINICAL TRAINING	15	N/A	5	28
ADM BLOCK GRANT	509	530	495	650
SUPPLEMENTAL TREATMENT GRANTS	163	170	-0-	195
SERVICES DEMONSTRATIONS	15	N/A	20	24
PROTECTION/ ADVOCACY	10.5	11.0	7.0	11.0
STATE PLANS	N/A	N/A	-0-	10

APPROPRIATIONS FISCAL YEAR 1988--ADAMHA--Continued

(in millions)

	FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
OFFICE OF SUBSTANCE ABUSE PREVENTION	41.5	N/A	11.2	65.0
DIRECT OPERATIONS	60.3	65.4	60.9	77.1

(* includes AIDS recommendations)

NATIONAL INSTITUTE OF MENTAL HEALTH RESEARCH

(in millions of dollars)

FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
$249	$288	$235	$330*

(* includes AIDS)

The proposed drastic cuts for the NIMH research budget are particularly distressing because the FY '87 budget passed by Congress demonstrated equal treatment of the NIMH research budget with those research budgets of other health-related agencies. The deep cuts proposed for the FY '88 budget would virtually close the door on much of the important mental health research supported by Congress at a time when it is the most promising.

In response to strong concern expressed by the public, research organizations, and Members of Congress, the Institute, in collaboration with mental health organizations and leading researchers is developing plans for a major initiative on research on schizophrenia and other major mental disorders. This effort will be mounted beginning in FY '88. Consequently, the recommendation for funding for NIMH has tried to anticipate initial funding for this major initiative. However, it is important that this initiative not be mounted by reducing support or orderly growth in other areas of mental health research which are described below. Furthermore, this initiative requires a long-term commitment over 3-5 years.

Schizophrenia

Schizophrenia remains one of the major public health problems in the United States in terms of morbidity, disability and mortality. There is increasing recognition of the importance of this condition and the suffering that it produces, while at the same time, advances in basic and clinical sciences hold increasing promise for major progress in understanding, treating, and preventing this illness (or illnesses). There has never been a sufficient basic scientific infrastructure established and overall research appropriations have been totally inadequate for the study of a disease whose sufferers occupy one-quarter of the nation's hospital beds and that accounts for more long-term disability than any other illness. Thus, a dramatic and creative approach is needed to provide the infrastructure and the expert manpower to promote scientific research of the scale and scope necessary to meet the challenge of schizophrenia. Such a program based on furthering the development of scientifically promising ideas, a needed infrastructure of clinical research beds and equipment, and the attraction, retention and most efficient use of scientifically trained personnel is needed. Our proposal would accommodate such a special initiative, as well as provide needed growth in all other programs.

AIDS

The mental health implications of this disease require increasingly intensive examination by the research community. The grave effects of HIV infection in the central nervous system are giving rise to a set of new questions around measuring, diagnosing and treating the cognitive and emotional impairments of AIDS. Questions surrounding the role of stress and depression make psychoneuroimmunology a pressing area of scientific investigation. Concerns involving maintenance of social support systems for HIV infected and immunocompromised individuals must be explored. It is vital that the NIMH assists in the development of methods to help people avoid specific sexual and drug using behaviors and in the design of public information and education campaigns.

The research agenda must also address broad issues of concern to society in general such as implications for the biological, psychological and social aspects of psycho-sexual development. Questions about the mental health implications of AIDS for health care service workers and the relationship of AIDS to other neurological and neuropsychiatric diseases must also be explored.

Serious Mental Disorders

Affective and Anxiety Disorders constitute the problems experienced by the majority of the mentally ill. The cost in distress to families and the loss in productivity is staggering. This proposal would allow investigators to develop new techniques in molecular genetics, biology, and psychosocial approaches to study and treat these disorders.

Prevention research is an area of increasing validity and significance. Although we do not know how to prevent major mental disorders, research on risk factors has provided directions for work that may lead to preventive interventions. With the additional resources, comprehensive initiatives can be developed for children at high risk for conduct disorders and depression which would contribute significantly in avoiding costly treatments.

Clinical disorders of childhood and adolescence are estimated to affect almost 12 percent of the school age population of the United States. The burden of mental disability for children and adolescents has become associated with increasing evidence of the most tragic consequences, including drug and alcohol abuse, educational and social dysfunction, and suicide. Our proposal would allow for the development of epidemiological data, as called for by the recent OTA Report, and exciting research on the role of the neuroendocrine system in childhood mental disorders.

The prevalence of mental disorders with serious symptomatology in the elderly range from 15-25 percent; the most frequent being Alzheimer's disease. Our proposal will allow for the expansion of research into areas of comorbidity and symptom management in Alzheimer's disease, geriatric depression, chronic mental illness and the relationship of mental disorders and physical illness.

Studies have shown increasing rates of serious mental disorders in rural areas, especially among adolescents. Depression among youth has been shown to be twice the national average, and a major study found 3 out of 100 youth having attempted suicide. Our proposal would provide approximately $5 million for the expansion of the NIMH effort to demonstrate the development of systems of care to address the serious mental health problems currently existing in rural America.

In contrast to the President's request, our proposal would permit:

- Award of approximately 450 new and competing extramural project grants to augment priority areas; and 20 new grants in the area of AIDS.
- Award of 10 new Clinical Research Centers in priority areas and 3 new Centers on AIDS all at Council-recommended funding levels.

- Critical increased support for Research Scientist Development Awards (which focus on developing a pool of talented young investigators); Cooperative Agreements; Contracts and Small Grants.

- Mental health services research including establishment of university centers as well as projects complementing existing Robert Wood Johnson and Medicaid demonstrations.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA) RESEARCH

(in millions of dollars)

FY '87	Current Services FY '88	President's FY '88	Our Proposal FY '88
$71.2	$82.2	$68.9	$89.5*

(* includes AIDS)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is the national focal point for alcohol research. Despite the terrible drain of human and economic resources resulting from alcohol abuse, research into its causes, consequences and treatment continues to be grossly underfunded. This inadequacy of support has been well documented over the years by the Institute of Medicine and others. For example, researchers have discovered a genetic predisposition to alcoholism in a significant number of cases and have identified two distinct subtypes of genetically-determined alcoholism. Important progress is being made in understanding the actions of alcohol at the cellular level. Evidence grows that alcohol interferes with the release of neurotransmitters in the brain. These and other recent findings have paved the way for future productive research in a wide range of scientific areas, providing knowledge that will impact our ability to treat alcohol problems.

Despite these major scientific advances and the identification of critical and immediate research opportunities, the President's budget would severely impede essential research on the physiological, biochemical and psychosocial bases of alcoholism, including urgent research on the development of an objective marker of alcohol consumption; the identification of reliable markers of the genetic susceptibility to alcoholism; the adverse effects of alcohol on every major component of the immune system; and the development of improved treatment and prevention strategies.

In contrast to the President's request, our proposal would permit:

- Award of approximately 130 new and competing research project grants at Council-approved levels, providing support for such high priority research as studies to identify biochemical markers of genetic susceptibility to alcoholism; research in the social sciences and neurosciences on the mechanisms of alcohol tolerance and addiction; and development of an objective marker of alcohol consumption to assist physicians in diagnosis. Special populations in need of further attention include children of alcoholics and individuals with diagnosed mental disorders, drug and/or alcohol-related problems. Funds should also be made available for evaluating various prevention and treatment approaches.

- Full funding and expansion of 12 existing Research Centers and the award of one new Center on Alcohol and Aging. This program has been remarkably successful in providing a strong focus for research in a wide range of areas.

- Expansion of the Intramural Research Program, including Nuclear Magnetic Resonance imaging technology; advanced molecular genetics (including the development of a gene bank); and social learning models in prevention and treatment efforts.

- Expansion of Research Scientist Development grants (with special emphasis on clinical researchers) and Epidemiology and Other Research Contracts.

- Initiation of grant programs to assist extramural researchers in meeting urgent needs for scientific instrumentation and facility renovation.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) RESEARCH

(in millions of dollars)

FY '87	Current Services FY '88	President's FY '88	Our Proposal FY '88
$132	$183	$106	$183*

(* includes AIDS)

The National Institute on Drug Abuse (NIDA) is the lead Federal agency responsible for supporting research directed at improving our understanding of the causes and consequences of drug abuse and developing improved drug abuse prevention and treatment techniques. The Institute of Medicine's landmark study, highlighting exciting research undertaken by NIDA, concluded that a successful attack on drug abuse will most likely come from knowledge of the complex biological, psychological, and social factors that reinforce drug-seeking and drug-using behavior.

Despite major accomplishments, many questions remain unanswered. There is clearly an urgent need to expand the range and intensity of research on cocaine. In addition to current studies on prevalence, there is a great need for longitudinal, prospective, community-based studies of cocaine use, so that information is available about how, why and when people get involved with cocaine: Little is know about the adverse effects of short and long-term cocaine use with respect to heart problems, congenital abnormalities, and long-term development. There are few, if any, controlled studies of specific treatment regimens, including the currently predominant method of behavioral contracting therapy, nor evaluation studies of various prevention approaches.

The President's popoal would significantly hinder prospective growth and progress in this important field of public health research. Almost one-half of this proposed increase is for AIDS-related research. Last year, the Congress authorized a significant increase in the NIDA research program. The President's budget for FY '88 is attempting to reduce that increase by 50 percent, indicating that the Congress intended for new monies to be allocated over a two-year period -- FY '87 and FY '88. We strongly request that the President's proposal be disapproved by the Congress. We are confident in the Institute's ability to spend new research monies on high quality, cost-effective research on drug abuse and on AIDS within FY '87. The Congress has already announced its intent to closely monitor the implementation of these new research monies and we support their interest and oversight.

In contrast to the President's proposal for FY 1987 and 1988, our proposal would:

- Utilize all FY '87 Drug Initiative research funds for new starts, thereby increasing the number of new and competing grants to 220.

- Target research funds proposed for deferral for new starts as originally planned.

- Provide a true "current services" budget for FY 1988 - maintaining the same number of new and competing projects provided in FY 1987 with funding at Council-approved levels.

- Support studies which closely examine the relationship between intravenous drug use and the spread of AIDS to children and the heterosexual population.

ADAMHA RESEARCH TRAINING

(in millions of dollars)

FY '87	Current Services FY '88	President's FY '88	Our Proposal FY '88
$23	N/A	$25	$32

While research training grants and fellowships are integral parts of the overall behavioral and biomedical research programs in this country, the number of research trainees supported by ADAMHA has declined steadily over the past several years, making it increasingly difficult to ensure an adequate supply of researchers in the important areas of mental health and addictive disorders. This pool of manpower must be greatly accelerated to keep pace with the exciting developments taking place in the research field. The Institute of Medicine (IOM) has strongly urged that research training funding be increased to attract more talented professionals to research careers, and specifically recommended more support of predoctoral and post-doctoral awards to avoid a projected shortfall of future behavioral and biomedical research scientists. The IOM pointed out that the training of researchers is especially important to fulfill the needs of evolving "specialty" areas without diminishing the continued needs of existing specialty areas. Current areas of exciting mental health research opportunities include: AIDS; schizophrenia; affective disorders; minority mental health; and childhood mental disorders. Areas of alcohol research requiring additional manpower include the genetics of alcoholism; biological and behavioral determinants of drinking; and alcohol's effects on the immune system.

We specifically urge increased research by and research training of minorities. A modest appropriation would establish within ADAMHA a program similar to the Research Centers in Minority Institutions program under the National Institutes of Health and enable more effective development of minority biomedical and behavioral research initiatives. The Minority Fellowship Program, Minority Access to Research Careers, Minority Biomedical Research Program, and Minority Research and Development Centers should be strengthened.

While we are pleased that the Administration has proposed a slight overall increase for research training, it is clearly not enough to remedy the consistent decline in mental health research training funds over the past several years or to meet the needs for investigators trained for alcohol or drug research. Our alternative recommendation would support 1,200 research trainees at NIMH, 140 trainees at NIDA, and 203 trainees at NIAAA, numbers consistent with the levels recommended in the IOM report. These funds would also support expansion of shortterm training programs to attract students in the health professions into research careers at early stages. The funds would allow NIAAA to increase training support in crucial areas of concern, including research on the genetics of alcoholism and treatment research. Our proposal would provide additional resources so that the NIMH could meet the biomedical, clinical, and behavioral goals of the IOM. Increased resources could be directed toward increasing the extemely small number of child psychiatrists and other childhood mental health professionals who are trained to conduct research; would allow for programs that specialize in integrating biological and psychosocial treatments; and would permit the NIMH to implement the recommendations of the Minority Research Task Force.

In addition, a major, and what we believe to be a critical research training initiative, would be launched through the Clinical Research Centers. This exciting initiative would ensure a steady and solid base of interdisciplinary trainees in the Centers which are sites of outstanding clinical research.

ADAMHA CLINICAL TRAINING

(in millions of dollars)

	FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
NIMH	14	N/A	5	26
NIDA/ NIAAA	1	N/A	0	2

The clinical training program continues to be a major source of training support for mental health professionals primarily in the fields of psychiatry, psychology, social work, nursing, mental health counseling and marriage and family counseling at universities and training centers in almost every state in the nation. According to the Institute of Medicine (IOM) report "Research on Mental Illness and Addictive Disorders", while one in every six persons suffers from a mental disorder or addiction at any one time, less than one-third of these people receive any form of treatment. The magnitude of this problem, as documented by the IOM, indicates a matter of national concern that cannot be adequately addressed at the state and local level.

Program funding only a decade ago averaged in the area of $70 million annually. While this Administration has proposed to terminate clinical training for the past six years, it recommends a nominal $5 million for FY 1988. Although Congress has consistently rejected these proposals, the funding level has declined drastically since 1980 to only $15 million in FY 1987. Unfortunately, there has not been a corresponding decline in the level of mental health needs in the country over this same period. With only $15 million to meet the mandates of the program -- no funds will be available for new initiatives or for expanding the critical initiative recently begun to train mental health professionals to treat individuals with alcohol and drug abuse problems. All of the funds are already obligated to ongoing commitments in Congressionally-mandated priority areas. We concur with last year's House and Senate Appropriations Committees' Report language in support of the NIMH Minority Fellowship Program, the State Manpower Development Program, and initiatives to train mental health professionals to work with underserved populations and in underserved areas. We believe that increasing program funding to $26 million will put the program back on track toward better meeting these important Congressional goals and priorities.

The NIAAA is currently supporting, jointly with NIDA, a limited program of clinical training. The clinical training programs of both institutes were dismantled in 1982, but the continuing urgent need to improve the treatment capabilities of health professionals led to a Congressional directive to support such activities within the funds appropriated for mental health training programs. In FY '85, $0.5 million was targeted to the joint health professions education program; $1 million was used in FY '86, and $1 million is again earmarked for this purpose in FY '87. An overwhelmingly positive response from the health professions education constituency groups led to three times as many meritorious proposals for funding than could be awarded. To assure the expansion of this systematic integration of substance abuse information into the core curriculum of health professional education we propose $1.0 million apiece -- under separate line items for NIAAA and NIDA Clinical Training -- to support alcohol and drug abuse education.

COMMUNITY SUPPORT PROGRAM AND OTHER SERVICES DEMONSTRATIONS

(in millions of dollars)

FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
$15	N/A	$20	$24

The National Institute of Mental Health (NIMH) Services Demonstration Program focuses on the unique problems of individuals with severe mental illness trying to become integrated into the community. Originally designed to serve adults, the Community Support Program (CSP) was expanded four years ago to serve children and adolescents who have severe emotional problems through the creation of the Child and Adolescents Service System Program (CASSP). CSP was again expanded in 1984 to serve homeless and elderly adults with severe mental illness. Funds are used to stimulate better planning and coordination of state and local programs by providing technical assistance and model community based service programs. Success is reflected in the increasing focus of state and local communities on the needs of these individuals; the substantial drop in hospitalization in the target populations; and the growth in applications to NIMH, far exceeding available resources.

However, funds have not kept pace with the increasing demands placed on the program. While the President's request does allow for new demonstration projects for homeless persons with mental illnesses, it does not permit the initiation of new demonstration projects to improve the community support system which -- if adequately developed -- could prevent homelessness. Of the President's request, $5 million is to be targeted for demonstration projects on services for mentally ill people who are homeless. Most of the remaining amount of the request is needed to continue existing demonstration programs. Therefore, few critical demonstration programs could be initiated for other priority population groups which includes deinstitutionalized adults, children and adolescents with severe emotional problems, and individuals with severe mental illness who move in and out of the hospital and correctional systems.

Our alternative recommendation of $24 million is necessary in order to:

- Fund 60 community service demonstration projects for innovative, coordinated services to mentally ill persons who are homeless or elderly and to young adults disabled by mental illness and substance abuse. Studies suggest that as many as 20 to 45 percent of the homeless have alcohol problems.
- Fund 35 State level system improvement projects.
- Fund 4 new comprehensive grants to demonstrate and widely disseminate the effectiveness of a comprehensive community support program approach at the State and local levels.
- Expand CASSP from the current level, which includes funding new local demonstration projects for seriously emotionally disturbed children and adolescents.
- Support research, training, and technical assistance efforts to continue needed services research, dissemination of information to state and local programs, assistance to family support groups and consumer self-help initiatives and critically needed training for staff at all levels.

STATE COMPREHENSIVE MENTAL HEALTH SERVICES PLANS
(in millions of dollars)

FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
No Authority	N/A	-0-	$10

Public Law 99-660, passed in 1986, among other purposes, authorizes grants to states to develop plans to establish and implement "an organized community-based system of care for chronically mentally ill individuals". Ten million dollars is authorized for each of fiscal years 1988 and 1989. Minimum allotments will be no less than $150,000 for preparation of such plans and states choosing not to develop and implement plans may be penalized by loss in future years of an amount equal to its expenses in 1986 for ADM Block Grant administration.

Few states are achieving a comprehensive care system for these citizens. On the one hand, states have in recent years systematically reduced hospital beds but, on the other, have generally failed to provide resources to take up the slack with adequate community mental health services. Housing needs are at crisis levels as clearly evidenced by the growing numbers of the mentally ill homeless. All states currently utilize advisory councils in creating state plans. The recent Office of Technology Assessment Report, "Children's Mental Health: Problems and Services" delineates the shortage of services to seriously emotionally disturbed children, particularly day treatment services. Funding this law will provide incentives to states (and their citizen advocates) to better define the problems and mobilize the political will within each state to undertake needed changes. Under the law each state must revise its advisory council to further assist the state in the planning and establishment of such a community-based system of care. Members must include representatives from a cross-section of state agencies with service programs (housing, Vocational Rehabilitation, Medicaid, social services, etc.) as well as other citizens who are providers, clients of mental health services and their families, and relevant professionals.

The law further specifies that the Secretary of HHS shall during 1988 develop -- and make available to the states -- a model plan for a community-based system of care for chronically mentally ill persons. State plans must contain quantitative targets, a description of accessible services (including rehabilitation, housing, other support services) with case management services for chronically mentally ill persons phased-in by FY 1992.

We urge the Congress to get this program underway with a full $10 million appropriation in FY 1988.

MENTAL HEALTH PROTECTION AND ADVOCACY PROGRAM

(in millions of dollars)

FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
$10.5	$11.0	$7.0	$11.0

The Mental Health Protection and Advocacy (P&A) System was established in FY 1986 by P.L. 99-319. Under the law, funds are provided by a formula to the existing state Protection and Advocacy Systems. Funds are utilized on behalf of persons with developmental disabilities; to protect and advocate for persons who have mental illness; and to investigate complaints of abuse and neglect in mental health facilities. Facilities include public and private hospitals, nursing homes, group homes, and board and care homes. The law authorizes persons who encounter a problem within 90 days of discharge to be eligible for services. The P&A system initiated extensive planning and start-up activities in FY 1986 and reached full implementation in FY 1987. Reports from across the country indicate a substantial volume of requests from mentally ill persons for assistance in a variety of settings including prisons, board and care homes, Veterans' Administration facilities, and state psychiatric hospitals and nursing homes.

The President's request of $7 million in FY 1988 funds is $3.5 million below the FY 1987 appropriation and $4 million below the authorization. This proposed decrease in the second full year of operation will cripple the ability of the program to meet its mandate.

The establishment of the Protection and Advocacy System for Mentally Ill Individuals provides for the first time advocacy services for a population that has a proven need for services. The program has begun operation and is guided by an advisory board with a majority of consumers. The expectations for services are high throughout the country and the programs are beginning to address the variety of problems, abuses and lack of services facing persons who are mentally ill. The program must therefore experience orderly growth to insure continued quality advocacy services. The proposed decrease will create confusion and delay in fully implementing the program and hamper the ability to protect a vulnerable population of citizens. We recommend an appropriation of $11.0 million, the full authorization level.

OFFICE OF THE ADMINISTRATOR
OFFICE OF SUBSTANCE ABUSE PREVENTION

(in million of dollars)

	FY '87 Approximate	Current Services FY '88	President FY '88	Our Proposal FY '88
Office of the Director	2.0	N/A	extend FY '87	2.5
Information Resources	5.0		extend FY '87	6.0
Community Assistance	7.5		extend FY '87	9.0
Demonstration Projects	20.0		6.5	38.0
Evaluation	1.0		extend FY '87	1.5
Direct Operations	6.0		4.7	8.0
TOTAL	$41.5		$11.2	$65.0

The Office of Substance Abuse Prevention was established under P.L. 99-570, the Anti-Drug Abuse Act of 1986. Located within ADAMHA's Office of the Administrator, OSAP functions as the focal point for our nation's alcohol and drug abuse prevention activities. A great deal of work has been conducted in developing and organizing the five divisions within OSAP. For example, the NIDA and NIAAA Clearinghouses have been combined into one new "Division of Information Resources". The Division of Community Assistance has arranged for grants for workshops and other initiatives that focus on youth, families, and special populations, as well as providing technical assistance to local communities and national groups. The Office of the Director is in place, and a major responsibility of that office will be coordinating activities with national corporations and foundations.

Of the amount appropriated for OSAP, $20 million is specifically mandated for demonstration projects for high-risk youth. The Coalition believes that these projects are vitally important and strongly supports OSAP's plans for early intervention initiatives and other activities aimed at high-risk youth. While funding for these demonstrations should be maintained, monies for demonstrations to focus on other drug and alcohol abusing populations are needed as well. For this reason, the Coalition recommends a substantial increase for demonstration projects in FY 1988.

Further, since the goals and objectives of the Office of Substance Abuse Prevention require highly labor-intensive activities, the Coalition recommends a $2 million increase in direct operations. While OSAP currently has 50 FTE's, the Coalition believes that at least 65 FTE's are needed.

Finally, and most importantly, the Coalition is concerned with attempts by the Administration to administratively allocate funds appropriated for FY 1987 over FY 1988 as well. The impact of this shortsighted policy would be to halve OSAP's budget and the funding available to prevent drug and alcohol abuse in this country. We recommend a rejection of this budget policy (as we have in the research domain) and an alternative appropriation for OSAP of $65 million.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT
AND STATE SUPPLEMENTAL ALCOHOL AND DRUG TREATMENT GRANTS

(in millions of dollars)

	FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
ADM Block Grant	$509	$530	$495	$650
Supplemental A & D Treatment Grants	$163	$170	-0-	$195

The ADM Block Grant is the foundation of funding for alcohol and drug abuse and community mental health services, helping to forge a partnership among federal, state and community-level providers. In 1981, alcohol, drug abuse and mental health categorical programs were consolidated into the Alcohol, Drug Abuse and Mental Health Block Grant as part of P.L. 97-35. The Block Grant is essentially two block grant programs within one authority, with different requirements and provisions for alcohol and drug abuse programs and community-based mental health services. The 1984 Amendments established a 10% set aside for seriously mentally disturbed children based on evidence that 7-10 million children are in need of mental health services. An additional 5% set aside for alcohol and drug-related services to women has had a dramatic impact on the states that have not had an increase in their awards since 1984 resulting, in some cases, in the elimination of services to other populations. In response to the drug treatment crisis, the Congress appropriated an additional $163 million in FY 1987 for the expansion of treatment capacity in the publicly funded service sector. This program requires reauthorization and much public concern is now being voiced about the inadequacy of its prior funding level.

The President's request of $495 million for the ADM Block Grant (considering the impact of inflation since 1986) would result in a decrease of $35 million in the purchasing power for existing services. This budget would not allow the nation to respond to the crisis of the large and growing number of people with serious mental illness who are homeless; would not allow the nation to meet the demand for alcohol and drug abuse services by the general public, DWI offenders, cocaine addicts and IV drug users who have been alerted to the spreading threat of AIDS among the IV populations; and would not continue the direction begun in 1984 to bring all states up to their appropriate share of funding.

We recommend an alternative appropriation of $650 million for the Block Grant and $195 million for the Supplemental Treatment Grants. The increased mental health funds are essential for the states to expand and create new community mental health intervention services for people with mental illness (particularly those who are homeless) and outreach services to locate this population both in the streets and in shelters. The alcohol and drug abuse monies would be used by states to support the basic service system and expand services to underserved populations (including women) identified by the states and communities.

DIRECT OPERATIONS
(in millions of dollars)

	FY '87	Current Services FY '88	President FY '88	Our Proposal FY '88
NIMH	33.2	35.0	34.2	40.2
NIAAA	9.7	10.9	9.9	12.8
NIDA	17.4	19.5	16.8	24.1

Direct operations activities provide essential program management services for the ADAMHA's research, training and services activities. Adequate staffing and program support are critical to insure the proper development and implementation of the three Institutes' programs. We have been concerned over the past several years of a gradual erosion of funds available to support activities which are essential to the support of research in particular. Curtailment of essential travel, publications, and communications expenses have been shown to result in waste and misdirection of millions of dollars. Recent cutbacks in the budget for collecting national statistics have been so severe that the continuation of this basic NIMH function is in jeopardy. Inadequate staffing at NIAAA has hindered program goals.

In contrast to the President's proposal, our recommendation would:

- Restore funding for the National Mental Health Statistics Program. Data gathered under this program are essential to the NIMH's capacity to provide information on incidence and prevalence of mental disorders, health care financing issues, treatment patterns in mental health facilities, and the homeless mentally ill.

- Implement the report of the Schizophrenia Task Force calling for meetings, seminars, publications and other non-research items presently not included in the current budget.

- Support contract research on services financing issues, including public service contracting, prospective payment options, catastrophic costs, and uncompensated care.

- Provide limited NIMH technical assistance funds to states.

- Provide NIDA and NIAAA with needed funds for site visitation and technical assistance to extramural research grantees; maintenance of the alcohol data base analysis of policy issues pertaining to alcohol and drug treatment; and technical assistance in dealing with AIDS and the homeless population.

With the passage of the Emergency Substance Abuse Treatment and Rehabilitation Block Grant (as part of the Drug Initiative of 1986), to be distributed to the states in part on the basis of capacity and need, it became apparent that current information is virtually non-existent on the ADM system capacity to deal with substance abuse problems. Little is known about the number or types of clients in need of or in treatment, the development or structure of organized providers, the system listing and referral process or the program and cost effectiveness of alternative treatment options. Failure to address these issues will continue to burden the State, Federal, and local capacity to access the existing substance abuse treatment system, limit the ability to improve system approaches to treatment, prevention and demand reduction, and impede the ability to make cost-effective decisions about the delivery of ADM services.

- For these reasons, an additional $5 million is requested to carry out necessary evaluation activities.

Senator DOMENICI. Let us proceed now, and instead of just bringing up two at a time, I think we have six chairs.

So why do we not have the next six witnesses, Charles Spielberger of the University of Southern Florida, Dr. Frazier, Dr. de Moss, Dr. Wiener of the American Academy of Child and Adolescent Psychiatry, Henry Work, and William Dewey.

Mr. Spielberger, you may proceed.

STATEMENT OF DR. CHARLES D. SPIELBERGER, PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF SOUTH FLORIDA, AND TREASURER, AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. SPIELBERGER. Thank you, Senator. I am Dr. Charles Spielberger, graduate research professor of psychology and director of the Center for Research in Behavioral Medicine and Health Psychology at the University of South Florida.

I am also national treasurer of the American Psychological Association, the largest scientific and professional organization of psychologists in the world.

On behalf of the APA's 87,000 members, I am pleased to testify on the subject of appropriations for the Alcohol, Drug Abuse and Mental Health Administration, and would like to point out that the funding levels recommended by APA are supported by a coalition of over 40 organizations involved in research, education and training and service delivery in the field of mental health.

Senator, as you are well aware, many exciting developments are taking place in mental health research. Psychologists are very much involved in this scientific revolution, which is rapidly advancing our understanding of mental disorders and addictions that affect as many as 45 million Americans.

Permit me to highlight just two examples. Schizophrenia research has resulted in increased awareness of the complex combination of psychological, social and genetic factors that contribute to development of this disorder.

Psychologists are involved in every aspect of research and the causes and treatment of schizophrenia from neurological research to the use of complex brain imaging techniques in identifying populations at high risk. Stress management for schizophrenics and their families has been a component of comprehensive treatment programs.

A second example focuses on AIDS research. While biomedical research has truly made extraordinary advances, great attention must be paid to the psychosocial and behavioral aspects of AIDS.

In many ways AIDS is a behavioral disease. It is transmitted via specific behaviors and the only means for stemming its transmission in the near future is behavioral in nature.

APA is encouraged by this committee's interest in and support of these and other research priorities of the NIMH, and we urge you to fund NIMH research at the level of $330 million for fiscal year 1988.

We are also encouraged by your action last year to increase to NIMH research funding commensurate with that received by the National Institutes of Health. APA believes that this action is well-justified, not only to make up for NIMH's past history of underfunding, but also because of the scientific vigor of current investigative efforts.

A related major concern of APA is the significant erosion in Federal training efforts in mental health. Although the administration has recommended a modest increase for NIMH research on training, this is insufficient to reverse the 35-percent decline in the number of research trainees supported by NIMH since 1980.

PREPARED STATEMENT

The rate at which behavioral and biomedical scientists are being trained must be greatly accelerated to take advantage of the exciting developments in the field. Thank you very much for this opportunity to testify before the committee.

Senator DOMENICI. Thank you very much, Doctor.

[The statement follows:]

Statement of Dr. Charles D. Spielberger

Mr. Chairman, Members of the Subcommittee, I am Charles D. Spielberger, Professor of Psychology at the University of South Florida. I am also Treasurer of the American Psychological Association (APA), which represents more than 87,000 psychologists in the United States. I am pleased to testify today on their behalf on the subject of fiscal year 1988 funding for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).

The funding levels advocated by APA were developed by a coalition of over 40 groups involved in mental health services delivery, research, education and training. We share a common purpose in working together to support the programs administered by ADAMHA. These programs are essential if we are to improve the lives of the 30 to 45 million Americans who suffer from mental or addictive disorders.

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) DIRECTOR

APA believes that the new director of the National Institute of Mental Health should be selected from a pool of candidates that includes women and ethnic minorities, and representation from psychology and other mental health disciplines. APA, along with 25 other national organizations, has been very concerned that only psychiatrists were being interviewed for this very important position, a position that requires an individual sensitive to the mental health needs of all populations and constituencies comprising the mental health community. Given over 200,000 psychologists, nurses, social workers and other nonpsychiatrists who are mental health scientists, educators, administrators and professionals, it was inconceivable to us that not one competitive candidate from these fields was being considered for the NIMH directorship. We are pleased that members of this Subcommittee have been supportive of our position and are gratified that ADAMHA has decided recently to broaden the search process so that candidates reflecting the diversity and interdisciplinary nature of the mental health field can be considered.

NIMH RESEARCH

APA recommends $330 million for NIMH Research in FY 1988. The research activities of NIMH encompass a wide range of psychological, social and biological scientific activities that are advancing our present knowledge of depression, schizophrenia, and other major mental health disorders. APA urges this Subcommittee to keep the NIMH research program on a forward track by approving a substantial increase in appropriations for FY 1988. This action would be in keeping with the findings of the 1985 Institute of Medicine (IOM) report, "Research on Mental Illness and Addictive Disorders", which concluded that research studies on mental and addictive disorders need to be doubled to take advantage of the rapidly emerging research opportunities in the mental health field. The APA-proposed budget would finance approximately 450 new and competing extramural project grants and 20 new grants for AIDS research. In contrast, the Administration's FY 1988 budget request of only $249 million for FY 1988 would fund only 274 new and competing research grants in FY 1988.

In addition, the FY 1988 NIMH research budget recommended by APA would accommodate the NIMH comprehensive schizophrenia research strategy that will focus on the possible behavioral and biological causes of schizophrenia, and on ways in which this disorder can be prevented. The contributions that psychologists are making span every aspect of research into the causes and treatment of schizophrenia - from basic neurological research involving animals; to using complex brain "imaging" techniques to identify certain populations at high risk of developing schizophrenia; to studying stress management for schizophrenics and their families as a component of a comprehensive treatment program.

Similarly, APA supports the Administration's request for additional appropriations for AIDS research at NIMH. We believe that the behavioral aspects of Acquired Immune Deficiency Syndrome (AIDS) require increasingly intensive examination by psychologists and others in the mental health research community. Additional research is needed on how individuals infected with AIDS cope with an incurable illness and on the mental health effects of stigma, prejudice and violence direct against persons or groups perceived to be carriers of the AIDS virus. Further, the grave effects of the HIV infection in the central nervous system give rise to new questions on measuring, diagnosing and treating the cognitive impairments of AIDS; and on the role of stress and depression as co-factors in the development of the frank expression of the AIDS syndrome.

Still another important research activity carried out by the NIMH involves mental health service systems research and data collection activities. APA recommends the addition of $6.0 million to the NIMH research budget to support grant and contract research on financing and service delivery systems, and $3.5 million to the NIMH direct operations budget to support the National Mental Health Statistics Program and related activities. We believe that report language is needed to direct the allocation of these resources to these important mental health services research programs and would be happy to work with you to develop language reflecting these concerns.

Moreover, APA also urges that NIMH be put on equal footing in this year's budget deliberations. We were gratified that, last year, the NIMH research program received funding increases commensurate with those received by the National Institutes of Health. Given NIMH's past history of underfunding and the erosion of federal support in this area, we believe that no less is required this year. Indeed, proportionately greater funding increases are merited not only to make up for lost ground, but also because of the scientific rigor of current investigative efforts in the field.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA) AND NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) RESEARCH

APA recommends that NIAAA research support be increased to $ 89.5 million and that NIDA research support be increased to $183 million in FY 1988. Promising new avenues for psychological and social research on substance abuse include epidemiological studies examining patterns of substance use across geographic regions; neurosciences research examining the relationships between drug action, behavior and the structure and function of the brain; research on how the spectrum of psychoactive drugs effect behavior change; and prevention research to develop more effective interventions to preclude drug use.

Last year, Congress significantly intensified federal support for research aimed at improving our knowledge of the causes, consequences and treatment of alcohol and drug abuse. Thus, the Administration proposal to allocate FY 1987 appropriations for the NIDA research program over a two-year period, thereby undermining the attack on drug abuse which has just been mounted, is especially troublesome. The appropriation of $89.5 million for NIAAA would support roughly 130 new and competing research grants, an increase of 19 grants over the current level and 41 grants over the Administration level. Approval of APA's recommendation of $183 million for NIDA would finance roughly 220 new and competing drug research grants in FY 1987 and approximately the same number in FY 1988. These recommendations will provide the continuity of funding required to sustain a systematic and long-term substance abuse research program.

ADAMHA RESEARCH TRAINING

APA recommends that Congress appropriate $25 million in FY 1988 to support a total of 1,200 research trainees at NIMH and increase support for predoctoral behavioral research training awards. Although the Administration has proposed to increase funding for NIMH research training, from $19 million in FY 1987 to $19.949 million in FY 1987, this proposal still is inadequate to ensure sufficient numbers of behavioral and biomedical scientists trained in mental health research. In its 1985 report, "Personnel Needs and Training for Biomedical and Behavioral Research", the IOM strongly urged that research training funding be increased to attract more talented mental health professionals to research careers. The IOM specifically recommended increased federal support at the predoctoral level in behavioral research.

APA also recommends that the FY 1988 NIAAA and NIDA research training budgets be increased to $ 2.6 million and $4.4 million respectfully. The Administration's budget figures of $2.4 million and $2.651 million for the respective NIAAA and NIDA research training budgets are woefully inadequate to stimulate the production of highly qualified scientists trained in the areas of alcohol and drug abuse.

APA's FY 1988 funding recommendations for other critical programs administered by ADAMHA are summarized (due to space limitations) as follows:

o	NIMH Clinical Training Program	$26 million
o	Alcohol, Drug Abuse and Mental Health Block Grant	$650 million
o	Supplement Alcohol and Drug Abuse Treatment Grants	$195 million
o	NIMH Community Support Program (CSP)	$24 million
o	Mental Health Protection & Advocacy Program	$11 million
o	State Comprehensive Mental Health Services Planning Grants	$10 million

STATEMENT OF DR. SHERVERT FRAZIER, PAST PRESIDENT, NATIONAL MENTAL HEALTH ASSOCIATION

Senator DOMENICI. Dr. Frazier?

Dr. FRAZIER. Senator Domenici, it is a real privilege and pleasure to be here today, especially since it is your birthday.

Senator DOMENICI. Thank you very much.

Dr. FRAZIER. Happy birthday.

Senator DOMENICI. Thank you. I am getting old.

Dr. FRAZIER. I want to tell you on behalf of the National Mental Health Association how much we appreciate what this subcommittee has done, what your committee did in years past, and what I am sure it will continue to do to support the major thrust of the National Institute of Mental Health as well as ADAMHA.

There is major funding which is needed to continue the major research programs in the basic, in the clinical and applied sciences, with a special reference to the major psychoses, schizophrenia, manic-depressive illness, as well as the other behavioral disorders, and is a very important of what we want to recommend again.

Your support for molecular biology and molecular genetics and research training, these are all very important. The imaging process, the AIDS, and so forth. This has already been emphasized.

In addition, the National Mental Health Association is also interested, since we do not have ideologies and do not have specific causes, we have a lot of sick people, a lot of needy people, and a lot of kids who have problems. And we need to pay attention to the services side of what their needs are.

This has to do with not just what their needs now are but how to prevent some of the problems, some of the grief problems, some of the loss problems, some of the stress problems, some of the lack of parenting problems, some of the investigations into suicidal behavior. A lot of prevention research needs to be considered and needs to be supported.

In addition, in the area of mental health services, we have a big need in the public sector especially for the training of professionals with the goal of taking care of the chronic mentally ill in a psychosocial rehabilitational kind of model, and also looking at how we can entice people into the public sector to provide the kind of services that these sick and suffering patients and their families need.

In order to do this we need clinical training, and that kind of money that goes, targeted populations, as well as a targeted payback kind of operation.

I want to also express the appreciation for the protection and advocacy money which was put in last time and the very great work that has occurred throughout this country and in numerous States as a result of many complaints and many people who have been suffering, even in the system. This protection and advocacy has been very effective.

I hope you will continue to expand the CSP, the Community Support Program with a special reference to the Child and Adolescent Support Program, because not all the States have yet had a chance to get the CASSP money.

The block grants also need to be supported. The State planning grants have been impressive. The $10 million that has gone for that. The rehabilitation process is now beginning to be a part of the understanding in the States and in the various mental health programs.

PREPARED STATEMENT

I appreciate what you have done. I hope you will continue with major funding in these areas.

Senator DOMENICI. Thank you very much, Doctor.

[The statement follows:]

STATEMENT OF DR. SHERVERT FRAZIER

Mr. Chairman, my name is Shervert Frazier, and I am Psychiatrist in Chief at McLean Hospital in Massachusetts. My statement today is presented on behalf of the National Mental Health Association (NMHA), a private, voluntary organization providing leadership to confront the entire range of mental health issues at local, state and national levels.

One in five American adults has a diagnosable mental disorder. I am speaking not only of patients in psychiatric hospitals and mentally ill people among the homeless, but of your neighbor and mine who is suffering from Alzheimer's disease, of spouses who are chronically depressed and withdrawn from all normal activities, of college age daughters who are starving themselves to death, victims of anorexia and bulemia, and of siblings, nieces and nephews who at 20 began exhibiting the terrible symptoms of schizophrenia.

And what of the children? A recent Office of Technology Assessment (OTA) report states that at least "12%, or 7.5 million, of the nation's approximately 63 million children suffer from emotional or other problems that warrant mental health treatment." Official data show a tripling of youth suicides since 1950 and it is probable that these figures do not even reflect actual incidence. And then there are the one in every 1,000 autistic children for whom there is still no broadly effective treatment and those children whose mental health has been seriously undermined by neglect and abuse; this last group, according to OTA estimates, is well over one million.

NMHA believes that we, as taxpayers, and you as legislators have a grave responsibility to do all that can be done to change these disturbing statistics.

RESEARCH: For many years, federal funding for mental illness suffered the same kind of stigma which was visited on those afflicted by it. The reasons put forward for long years of underfunding ranged from denial that these are real ilnesses to blaming the field, rather than the inadequate support, for limited progress. More realistic funding is changing the picture and recent investments in mental health research are paying off. The newly acquired knowledge is spilling over into the entire medical field.

New imaging techniques continue to produce information almost faster than the field can process it. Abnormal chemical and metabolic changes are being documented and studied, the dysfunctions are being charted. Brain imaging technology is a tool of tremendous potential but it is only one of the many now being used to unlock the mystery of mind and body.

Within just the past few months, researchers using techniques of molecular biology have reported major new genetic discoveries relating to two of society's most prevalent and costly illnesses--Alzheimer's Disease and manic depression. The findings signal a new era in the application of molecular genetic research methods to the understanding of psychiatric disorders and the identification of their physiological base. The savings which can accrue from such treatment breakthroughs are astounding. It has been estimated that lithium has saved billions in treatment costs of manic depression and new studies have led to the use of Tegretol with patients resistant to lithium with highly encouraging results. With effective intervention now a reality, getting patients to accept and stay in treatment is the focus of new psychological research at NIMH, since less than one third of depressed patients seek help.

NIMH is now planning a comprehensive and sustained research initiative on schizophrenia. Such an initiative will focus on identifying the genetic and development aspects of schizophrenia and uncovering its neurogenetic base using a large cohort of families over many years. We will be able to study the chemical substances involved in communication between nerve cells and examine the heterogeneity of schizophrenia and the relationship of schizophrenia to other psychoses. I would hope this initiative will also enable us to understand treatment responsiveness, drug dosage requirements and side effects and to identify high risk individuals.

The synergistic effect of emotional functioning on the body's immune system has spawned a new area of study, psycho-immunology, with special relevance to AIDS and also new opportunities in schizophrenia studies. Since depression seems to lower immunity and there is a high incidence of pre-existing depression among populations at high risk for AIDS, treatment of depression could impact on lowered immunity to AIDS.

We urge you to increase the NIMH appropriation for mental health research, including AIDS, to $330 million. Of that amount we urge special attention to the following areas.

Mental Health Services Research: We recommend an increase of $6 million in FY 1988 for mental health services research so as to restore the NIMH statistical program, initiate six new mental health research centers to conduct research on the financing, organization and delivery of services, including studies of the unique Robert Wood Johnson Foundation demonstration of systems of care for chronically mentally ill people.

Prevention: We need to step up prevention research efforts. With a new prevention initiative to address drug abuse, we must not neglect the need for more responsible mental health treatment approaches and the need to better understand teenage behavior, including family interactions. According to the Center for Disease Control, each year 500,000 youngsters threaten suicide, and in 1984 5,000 were successful. It is the second leading cause of death among young people and the rates are rising; official data show a tripling of youth suicides since 1950. The OTA report, cited earlier, comments, "not only have many prevention programs led to positive changes in social, emotional and academic measures, but such programs appear capable of preventing later governmental expenditures through the justice and welfare systems." We must continue to invest in such cost-effective research.

Neurosciences Building: We ask you to appropriate $7 million to allow NIMH to be part of the new Neurosciences building on the NIH Campus so as to share extremely expensive equipment and provide opportunities for cross linkages which are ever more important.

Research Training: Examples of the field's impressive promise are legion, but that promise will not be fulfilled without a constantly replenished supply of highly skilled personnel necessary to conduct that research. We urge an appropriation of $32 million for research training.

MENTAL HEALTH SERVICES: We are encouraged by Congressional interest and support for community based programs geared to people with serious mental illnesses. This Committee has been instrumental in its support for the Protection and Advocacy program, the Community Support Program and other services initiatives.

Protection and Advocacy: The P&A system reached full implementation in FY 1987 and reports from across the country indicate a substantial volume of requests for assistance from a variety of settings, including prisons, board and care homes, VA facilities, state mental hospitals and nursing homes. Expectations for this program are high, and we therefore urge full appropriation of $11 million.

Mental Health Services (CSP/Demonstrations/Planning/Block Grant/Training): It is essential that we complement our increased efforts on mental health research, with appropriate strides forward in bringing the most effective services to those who are now in need. Study after study has underscored the social and economic value of such programs.

For instance, the rehabilitative approach used in many CSP programs, and now encouraged through new initiatives in the NIMH clinical training program, shows solid results. The competitive employment rate of seriously mentally disabled individuals is estimated to be 5-10%, but a recently released Fountain House study indicates that this same population, when involved in mental health rehabilitation transitional employment programs were 35-40% employed. Similarly encouraging data has come from Chicago where patients enrolled in a comprehensive psychosocial rehabilitation center reduced their rehospitalization rate from 44% to 14%. Success like this warrants your support.

We urge funding the NIMH demonstration initiative at $24 million which will enable expansion of all CSP efforts and increasing attention to demonstrating effective techniques for meeting the needs of homeless people. We also urge a significant increase for the mental health services block grant, following reauthorization and amendments to improve that law which the Labor and Human Resources Committee will be considering. With those amendments, which will focus block grant dollars on new creative and flexible programs for high risk populations, we urge an appropriation of $350 million for mental health services. It is also extremely important to initiate funding for the new mental health planning legislation, designed to coordinate the various services required to assist seriously mentally ill people to live successfully in the community, such as clinical vocational rehabilitation, housing, and social services. Such planning can have a significant impact on improving coordination of services, and have a direct benefit in preventing homelessness.

We also support continuation of the clinical training program, with directives to NIMH to focus on the needs of seriously mentally ill people needing community services.

In 1987, Congress appropriated $1.2 million to initiate services in rural states, particularly those affected by the farm crisis. In 1988, we urge an increase to $5 million. Almost 50% of US farms are predicted to fail over the next ten years, resulting in drastic and permanent changes in rural communities. Funds should be used to support systems of care which coordinate mental health, health, vocational training and counselling.

STATEMENT OF DR. ERNEST DE MOSS, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Senator DOMENICI. Dr. de Moss?

Dr. DE MOSS. Senator Domenici, this statement represents the views of the National Alliance for the Mentally Ill.

The alliance, now nearly 7 years old, consists of family members of mentally ill persons as well as mentally ill citizens themselves. The illness in our organization's name refers to severe debilitating, disabling mental illnesses, notably schizophrenia and manic and major depression.

It is useful to remember that the NIMH research program declined markedly in the late 1960's and 1970's. NIMH moved out of the National Institutes of Health in 1967 and the loss in research money has been referred to by previous speakers.

More importantly I want to point out that the loss in purchasing power of the NIMH research programs was not shared in by institutes in the NIH complex, and we would like certainly to get back on track.

I refer to these historical elements only to put in perspective the fact that notwithstanding the increases given to the NIMH research program by Congress in recent years, it still is an underinvested area.

The public costs of serious mental illnesses have been widely documented. We come to you again this year and plead for a greater investment in NIMH research programs.

You have heard about the exciting schizophrenia initiative given priority and momentum under the very able Dr. Shervert Frazier, who preceded me on this talk today before he left his NIMH office last December.

Estimates based on present progress suggest that beginning in October research projects identified by this schizophrenia initiative could easily absorb $90 million or more.

I hope this subcommittee will have at hand a current status report of that progress when you mark up your fiscal year 1988 appropriations so that you will have ample justification for a significant increase in funds to give force to this important scientific development. A byproduct of this effort is the attention it is getting from young scientists who have not yet committed themselves to career choices.

While I have highlighted research on schizophrenia Iwant to speak to the need for more funds for depression and other major mental illnesses. We join with many other groups in asking for a research budget that would rise to $330 million for fiscal year 1988.

I want to commend this committee, particularly some of its members such as you, Senator Domenici, for its concern for the homeless American.

Effective aid for homeless mentally ill citizens must be multiyear in scope and must augment mental health services in ways that meet the needs of these citizens through outreach case management, transitional housing, medical assistance and opportunities for rehabilitation, leading to employment.

We would like to see continuation of the NIMH community support program and particularly call your attention to Public Law 99–660, which is concerned with comprehensive mental health services in communities. This has not been funded and we would like to see the $10 million which the program requires go back into the program.

In conclusion I hope you will consider the important role of the Federal Government in research on mental illness and in providing incentives for adequate community care for mentally ill citizens.

Our budget recommendations for all of the programs of NIMH are contained in a coalition document on funding recommendations for ADAMHA, already submitted to this subcommittee.

PREPARED STATEMENT

Thank you for the opportunity to present the views of the families having heartbreaking mental illnesses within our ranks. And I am a parent, and I thank you for the time.

[The statement follows:]

Statement of Dr. Ernest de Moss

MR. CHAIRMAN, THIS STATEMENT REPRESENTS THE VIEWS OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL. THE ALLIANCE, NOW NEARLY SEVEN YEARS OLD, CONSISTS OF FAMILY MEMBERS OF MENTALLY ILL PERSONS AS WELL AS MENTALLY ILL CITIZENS THEMSELVES. THE ILLNESS IN OUR ORGANIZATION'S NAME REFERS TO SEVERE, DEBILITATING, DISABLING MENTAL ILLNESSES -- NOTABLY SCHIZOPHRENIA AND MANIC AND MAJOR DEPRESSION.

I AM PRESIDENT OF THE ALLIANCE FOR THE MENTALLY ILL OF MONTGOMERY COUNTY MARYLAND. MY WIFE AND I ARE ACTIVE MEMBERS OF THE NATIONAL ALLIANCE AND ARE PARENTS OF A MENTALLY ILL SON. THE NATIONAL ALLIANCE, A SELF-HELP ORGANIZATION, CONTINUES TO GROW AT AN INCREDIBLE RATE. THERE ARE NOW 730 CHAPTERS IN ALL STATES, MADE UP OF MORE THAN 43,000 FAMILY MEMBERS. FORTY-THREE STATES HAVE ESTABLISHED STATE ALLIANCE ORGANIZATIONS IN ORDER TO PRESENT A SINGLE VOICE TO STATE GOVERNMENTS CONCERNING THE NEEDS OF SERIOUSLY MENTALLY ILL PERSONS.

WE APPRECIATE THE OPPORTUNITY TO EXPRESS OUR VIEWS, AS WE HAVE NOW FOR A NUMBER OF YEARS, TO THIS SUBCOMMITTEE CALLING FOR A SUBSTANTIAL INCREASE IN THE U.S. GOVERNMENT'S INVESTMENT IN RESEARCH ON SERIOUS MENTAL ILLNESS. IN THE PAST THREE YEARS YOU HAVE STEADILY INCREASED THE RESEARCH BUDGET OF THE NATIONAL INSTITUTE OF MENTAL HEALTH. YOU HAVE IN YOUR COMMITTEE REPORTS CALLED FOR MORE ATTENTION TO SCHIZOPHRENIA RESEARCH. LAST YEAR THIS SUBCOMMITTEE SET ASIDE $5 MILLION TO UPGRADE NIMH'S SCHIZOPHRENIA RESEARCH. THESE ACTIONS HAVE BEEN CLOSELY NOTED AND APPRECIATED BY THE FAMILIES WITH A FAMILY MEMBER AFFLICTED WITH SCHIZOPHRENIA.

IT IS USEFUL TO REMEMBER THAT THE NIMH RESEARCH PROGRAM DECLINED MARKEDLY IN THE LATE SIXTIES AND SEVENTIES. NIMH MOVED OUT OF THE NATIONAL INSTITUTES OF HEALTH IN 1967. ITS RESEARCH BUDGET THAT YEAR WAS $103 MILLION. IN THE FOLLOWING YEARS IT WENT AS FOLLOWS (in millions): 102, 99, 92, 96, 95, 85, 90, 92, 94, 104, 111, RISING TO 130 IN 1979, THE YEAR NAMI WAS ESTABLISHED. DURING THOSE YEARS INFLATION ATE AWAY AT THE PURCHASING POWER OF THOSE RESEARCH DOLLARS. BETWEEN 1969 AND 1976, MORE THAN 30% OF THE PURCHASING POWER WAS ERODED BY INFLATION.

MR. CHAIRMAN, THIS DID NOT HAPPEN IN THE INSTITUTES OF THE NIH. DURING THOSE YEARS, I WORKED AS A RESEARCHER AT THE NATIONAL CANCER INSTITUTE, FROM WHICH I AM NOW RETIRED. DURING THOSE YEARS WHILE THE NIMH RESEARCH BUDGET LOST PURCHASING POWER, THE NIH INSTITUTES WERE GIVEN INCREASES BY CONGRESS TOTALING MORE THAN A 30% INCREASE IN REAL DOLLARS.

I REFER TO THIS HISTORY ONLY TO PUT IN PERSPECTIVE THE FACT THAT, NOTWITHSTANDING THE INCREASES GIVEN TO THE NIMH RESEARCH PROGRAM BY CONGRESS IN RECENT YEARS, IT STILL IS AN UNDER INVESTED AREA. THE PUBLIC COSTS OF THE SERIOUS MENTAL ILLNESSES HAVE BEEN WIDELY DOCUMENTED. WE COME TO YOU AGAIN THIS YEAR AND PLEAD FOR A GREATER INVESTMENT IN THE NIMH RESEARCH PROGRAM. WE HAVE ASKED THIS COMMITTEE AND WE HAVE PRODDED NIMH TO PUT INCREASING AMOUNTS FOR RESEARCH ON MENTAL ILLNESS.

AS A FORMER RESEARCHER WHO FOLLOWS THE EXCITING STRIDES BEING MADE IN BRAIN RESEARCH, IN THE AREAS OF MOLECULAR BIOLOGY, TO NAME JUST TWO AREAS OF PROMISE, THERE HAS NEVER BEEN A BETTER TIME FOR INCREASING OUR INVESTMENT IN RESEARCH

TO FIND THE CAUSES AND BETTER TREATMENTS FOR SERIOUS MENTAL ILLNESS THAN THE PRESENT TIME.

RECENTLY WE ALL LEARNED IN OUR NEWSPAPERS THAT SCARCE NIMH RESEARCH DOLLARS FUNDED THE RESEARCH THAT DISCOVERED THAT SOME CASES OF MANIC DEPRESSION ARE LINKED TO SPECIFIC GENETIC DEFECTS. THIS IS AN ENORMOUS STRIDE. IT IS THE PRODUCT OF YEARS OF RESEARCH SUPPORTED BY NIMH WITH THE DOLLARS PROVIDED BY CONGRESS.

YOU HAVE HEARD ABOUT THE EXCITING SCHIZOPHRENIA INITIATIVE, GIVEN PRIORITY AND MOMENTUM UNDER THE VERY ABLE DR. SHERVERT FRAZIER BEFORE HE LEFT NIMH LAST DECEMBER. A NEW SCHIZOPHRENIA RESEARCH BRANCH WITHIN THE EXTRAMURAL PROGRAM HAS BEEN ESTABLISHED AND THE STAFF HAS DOUBLED TO 13 PERSONS. A NEW CLINICAL RESEARCH LAB IS BEING ESTABLISHED WITHIN THE INTRAMURAL RESEARCH PROGRAM. AND TWO NEW SCHIZOPHRENIA RESEARCH CENTERS HAVE BEEN DESIGNATED.

THESE ARE TRULY PACE-SETTING DEVELOPMENTS. UNDERWAY IS A PROCESS FOR THE DEVELOPMENT OF A NATIONAL PLAN FOR RESEARCH ON SCHIZOPHRENIA. ESTIMATES BASED ON PRESENT PROGRESS SUGGEST THAT BEGINNING IN OCTOBER, RESEARCH PROJECTS IDENTIFIED BY THIS PLAN COULD EASILY ABSORB $90 MILLION OR MORE. I HOPE THIS SUBCOMMITTEE WILL HAVE AT HAND A CURRENT STATUS REPORT OF THAT PROGRESS WHEN YOU MARK-UP YOUR 1988 APPROPRIATIONS SO YOU WILL HAVE AMPLE JUSTIFICATION FOR A SIGNIFICANT INCREASE IN FUNDS TO GIVE FORCE TO THIS IMPORTANT SCIENTIFIC DEVELOPMENT. WHAT A PITY IT WOULD BE IF THIS OPPORTUNITY WERE STARVED BECAUSE OF TOO FEW DOLLARS.

A BY-PRODUCT OF THIS EFFORT IS THE ATTENTION IT IS

GETTING FROM YOUNG SCIENTISTS WHO HAVE NOT YET COMMITTED THEMSELVES TO CAREER CHOICES. WE BADLY NEED THEM IF THIS RESEARCH EFFORT IS TO SUCCEED. A SCIENTIST FRIEND WHO RECENTLY ATTENDED AN NIMH-SPONSORED SCHIZOPHRENIA RESEARCH MEETING SAID, "IT IS IMPRESSIVE TO SEE HOW RAPIDLY THE WORD IS GETTING OUT THAT RESEARCH ON SCHIZOPHRENIA HAS A FUTURE."

AGAIN THIS YEAR, THE NATIONAL ALLIANCE HAS JOINED A HOST OF OTHER ORGANIZATIONS TO ASK CONGRESS FOR SIGNIFICANT INCREASES IN THE NIMH RESEARCH BUDGET. WHILE I HAVE HIGHLIGHTED RESEARCH ON SCHIZOPHRENIA, I WANT TO SPEAK TO THE NEED FOR MORE FUNDS FOR DEPRESSION AND OTHER MAJOR MENTAL DISORDERS. WE JOIN WITH MANY OTHER GROUPS IN ASKING FOR A RESEARCH BUDGET THAT WOULD RISE TO $330 MILLION FOR FISCAL YEAR 1988.

I WANT TO COMMEND THIS COMMITTEE, PARTICULARLY SOME OF ITS MEMBERS SUCH AS SENATOR DOMENICI, FOR ITS CONCERN FOR HOMELESS AMERICANS. WE ARE PARTICULARLY CONCERNED WITH THE HOMELESS MENTALLY ILL WHO MAKE UP BETWEEN 25 AND 50% OF THE HOMELESS POPULATION. THEY HAVE SPECIAL NEEDS. THE LEGISLATION IN CONFERENCE RESPONDS TO THOSE SPECIAL NEEDS.

BUT I WANT TO MAKE THE POINT THAT ONE-SHOT EMERGENCY AID FOR HOMELESS MENTALLY ILL PERSONS DOES NOT RELIEVE THE LARGER PROBLEM OF AN INADEQUATE SYSTEM OF COMMUNITY BASED SERVICES IN VIRTUALLY EVERY COMMUNITY AND STATE. EFFECTIVE AID FOR HOMELESS MENTALLY ILL CITIZENS MUST BE MULTI-YEAR IN SCOPE AND MUST AUGMENT MENTAL HEALTH SERVICES IN WAYS THAT MEET THE NEEDS OF THESE CITIZENS THROUGH OUTREACH, CASE MANAGEMENT, TRANSITIONAL HOUSING, MEDICAL ASSISTANCE, AND OPPORTUNITIES FOR REHABILITATION LEADING TO EMPLOYMENT.

NIMH'S COMMUNITY SUPPORT PROGRAM, WHICH THIS SUBCOMMITTEE HAS HISTORICALLY SUPPORTED, HAS BEEN A GUIDING LIGHT, IN SO MANY STATES HELPING THROUGH MODEST DEMONSTRATION GRANTS, TO IDENTIFY THE SERVICES NEEDED BY THE MENTALLY ILL. I HOPE YOU WILL SEE FIT TO CONTINUE FUNDING THIS PROGRAM AT ITS MAXIMUM AUTHORIZATION. CSP IS A TRUE SUCCESS STORY.

I WANT TO CALL YOUR ATTENTION TO P.L.99-660, THE STATE COMPREHENSIVE MENTAL HEALTH SERVICES PLAN ACT OF 1986. IT AUTHORIZES $10 MILLION BEGINNING IN FY 1988. WE THINK THIS MODEST LAW IS IMPORTANT BECAUSE IT FOCUSES EXCLUSIVELY ON THE SERIOUSLY MENTALLY ILL. IT PROVIDES INCENTIVES FOR STATES TO DEVELOP PLANS (AND CARRY THEM OUT) FOR A COMMUNITY-BASED SYSTEM OF CARE FOR THE SERIOUSLY MENTALLY ILL. IT INVOLVES THE FAMILIES IN THE PROCESS. IT ADDS UP TO AN OPPORTUNITY TO TAKE BEFORE STATE LEGISLATURES A SENSIBLE PLAN OF CARE FOR THESE PEOPLE WHO ARE, IN MOST PLACES, PRESENTLY INADEQUATELY CARED FOR BY MENTAL HEALTH SYSTEMS.

THE ADMINISTRATION DID NOT REQUEST FUNDS FOR THIS NEW PROGRAM. WE ASK THAT YOU FUND IT AT THE FULL $10 MILLION SO THAT THE LEVERAGING OPPORTUNITIES IT PROVIDES CAN BE DEVELOPED TO GET STATES TO TAKE UP A GREATER SHARE OF THE BURDEN.

IN CONCLUSION, I HOPE YOU WILL CONSIDER THE IMPORTANT ROLE OF THE FEDERAL GOVERNMENT IN RESEARCH ON MENTAL ILLNESS AND IN PROVIDING INCENTIVES FOR ADEQUATE COMMUNITY CARE FOR MENTALLY ILL CITIZENS. THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT WILL BE RE-AUTHORIZED THIS YEAR. WE HOPE IT WILL PROVIDE GREATER FLEXIBILITY THAN IN THE PAST TO MEET THE NEEDS OF THE SERIOUSLY MENTALLY ILL.

OUR BUDGET RECOMMENDATIONS FOR ALL THE PROGRAMS OF NIMH ARE CONTAINED IN A COALITION DOCUMENT ON FUNDING RECOMMENDATIONS FOR ADAMHA ALREADY SUBMITTED TO THIS SUBCOMMITTEE. WE DID NOT RUBBER STAMP THESE RECOMMENDATIONS, BUT ACTIVELY PARTICIPATED IN AGREEING TO THEM BASED UPON CAREFUL AND CONSIDERED JUDGMENTS.

THANK YOU FOR THE OPPORTUNITY TO PRESENT THE VIEWS OF THE FAMILIES HAVING HEARTBREAKING MENTAL ILLNESSES WITHIN OUR RANKS.

Senator DOMENICI. Thank you very much, Doctor.

Before we proceed to Dr. Wiener, let me just tell you a story. A few of you know Nancy, my wife. She took your place yesterday before the House subcommittee and testified on behalf of the alliance. I wish I had her wit.

The chairman apparently welcomed her and proceeded to give about a 3-minute statement about what a great Senator I am with Nancy sitting there.

And I guess he expected a different comment from her, but when he was finished he asked her if she was not proud, and instead of answering that she said, well I think I will have to cook him a hot meal this evening. [Laughter.]

And then the Senate proceeded to stay in till 12:30 last night. But what none of them knew is that my wife is not a very good cook, so nobody knows what she was talking about. [Laughter.]

We did get a tape of her speech, but we did not get a live tape of her comments. The tape did not come on in time.

But in any event, Dr. Wiener, we welcome you. It is a pleasure to see you again.

STATEMENT OF DR. JERRY WIENER, CHAIRMAN, DEPARTMENT OF PSYCHIATRY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, AND PRESIDENT-ELECT, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

Dr. WIENER. Senator, thank you very much. It is a particular pleasure for me to be able to present my comments to you, knowing of your support in the past for this issue.

I was about to wish you a hot meal for your birthday, but think the better of it now. [Laughter.]

Senator, I want to express for the American Academy of Child and Adolescent Psychiatry, as its president-elect, my support for the proposed size of the research budget for the National Institute of Mental Health, and for the research training budget of the National Institute of

Mental Health. Those are both very critical and we support them without reservation.

I do want to limit my remarks this afternoon to urging support by the subcommittee and by the Congress for the appropriation for clinical training in particular, and the support for community programs. Those are two critical training and service program support areas that are badly in need.

Training and clinical training is really our investment in services for the future. It is also our investment in those people who will be able to do the research in the future. Without continued support clinical training and without translating that into State support for services, we do not get the full return on our dollar.

Now, I am particularly concerned about clinical training support for child and adolescent psychiatry training programs. We would urge that the current appropriation of $15 million be increased to $28 million, and much more than the administration recommendation.

Clinical training for child and adolescent psychiatry supports an area of service that has been identified as most in shortage of all specialty areas in medicine. The training programs in child and adolescent psychiatry provide an enormous amount of services to populations in need that would otherwise not be able to afford services and not have services available if they were able to afford them.

It is a critical shortage area. I urge you to increase the appropriation. Right now only 80 of 200 child and adolescent training programs can be funded and the funding is limited in all of those instances, so that with an increased appropriation there would be increased funding for this particular shortage area.

PREPARED STATEMENT

I would stop there, having made that point, which I think is critical in the clinical training budget, and answer any questions that you might have.

[The statement follows:]

Statement of Dr. Jerry Wiener

The American Academy of Child and Adolescent Psychiatry appreciates this opportunity to present a statement for the Subcommittee's hearing on the President's 1988 budget request for the National Institute of Mental Health.

I am Dr. Jerry Wiener, Chairman of the Department of Psychiatry at George Washington University and President-elect of the American Academy of Child and Adolescent Psychiatry. Today, I would like to urge members of this Subcommittee to support those programs within the National Institute of Mental Health that are important to the treatment and services for children and adolescents. NIMH programs have a continued influence on the direction of research and training for the diagnosis and treatment of psychiatric disorders in children and adolescents.

The American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry is a national, professional association of over 3600 child and adolescent psychiatrists. Its members are physicians who have completed a general psychiatry residency and two years additional residency training in child and adolescent psychiatry. This medical discipline is concerned with the prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and families. These disorders include affective illness, attentional deficit disorders and learning disabilities, schizophrenia, substance abuse, eating disorders, suicide and conduct disturbances. The Graduate Medical Education National Advisory Committee reviewed the service requirements for treating the psychiatrically ill children and adolescents in this country and recommended that a range of 8,000 to 10,000 child psychiatrists be required for 1990. Without the encouragement from Congress through the National Institute of Mental Health, that range may be reached only in the distant future.

RECOMMENDATIONS

In the past, the Subcommittee has consistently voted to continue funding for NIMH programs that were eliminated from the Administration's budget. You recognized the importance and responsibility of providing support for training, research and support services for persons with psychiatric illnesses. In recent years, your specific language regarding the special needs of seriously emotionally disturbed children and adolescents has resulted in the growth of the Child and Adolescent Service System Program (CASSP), which allows states to coordinate efforts on children's overstretched services. The Academy recognizes your support and understanding of the importance of treating children and adolescents rather than waiting to treat adults with more advanced and complicated illnesses.

For FY 1988, the Academy recommmends the following appropriations be made for these NIMH programs:

for clinical training........$28 million,
for intramural and extramural research.........$330 million,
for research training........$32 million, and
for the Community Support Program (CSP), which includes the
Child and Adolescent Service System Program..$24 million.

The Administration has requested only $5 million for clinical training and $20 million for the service demonstration programs. This is an increase over the zero funding requested each previous year; however, the special needs for training, research and services for children and adolescents with emotional illnesses remain largely unmet and in need of increased support.

CLINICAL TRAINING

The American Academy of Child and Adolescent Psychiatry believes that if the clinical training program at NIMH is continued with stronger support in FY 1988, and if the Congress will once again mandate an emphasis on programs for chronically emotionally disturbed children, a step will be made in the direction of meeting the needs of children. Currently, NIMH can support only 80 of 200 clinical training grants in the priority area of child and adolescent mental health. Of the $15 million appropriated for clinical training in FY 1987, about $3,300,000 is spent on children's programs. And the $15 million is a 25 percent cut from the original $20 million request, a cut that meant no new grants could be awarded this year. Furthermore, because training grants are for three years, the 42 grants now in their third year will be terminated rather than considered for competing renewal application. The newest programs, those with a child focus, will have the most difficulty sustaining themselves unless additional support becomes available.

It should be emphasized that funds supporting training programs in child and adolescent psychiatry are used to support faculty, not individual trainee stipends. This represents a major multiplier effect in the multitude of benefits generated by contributing to the education of mental health professionals through child and adolescent psychiatry faculty members. When two out of three seriously emotionally disturbed children in this country are not receiving appropriate services, those programs that support training of mental health professionals who can treat these children should be encouraged. By recommending an appropriation of at least $28 million for clinical training at NIMH, the Congress would be encouraging expanded, effective training programs. The funds would directly affect training, by attracting and supporting additional teaching faculty; by developing improved and expanded educational programs able to attract new students; by increasing faculty support for minority programs, and programs with increased emphasis on chronic mental illness; by improving consultation/liaison activities with primary care physicians and other mental health professionals; and by allowing the addition of new programs on day treatment, family therapy, and chronic medical illness.

Loss of support for clinical training would result in decreased services to populations served by subsidized training programs; a decrease in the quality and quantity of training; a limit to new programs and problems with trainee recuitment;
a fragmentation of faculty and loss of faculty time for evaluation, a loss of emphasis on the underserved, children and the aging, with specific losses in outreach programs; and a major loss of support when states do not have the encouragement to add their support to clinical training programs. When the federal government provides some assistance for a program, even if the support is a minor part of the total budget, a state and community are far more willing to share the costs.

Clinical training support is an investment. It ensures attention to children and adolescents who are at risk for mental illnesses such as depression, Attention Deficit Disorder, schizophrenia, and autism. Private sources cannot generate the state and community support given by the federal program through NIMH. Training programs are difficult to assemble and expensive to recreate once they have been removed. The American Academy of Child and Adolescent Psychiatry recommends a budget level of $28 million for FY 1988 for the NIMH clinical training program in order that training programs can continue -- enhanced -- and without fear of termination.

Thank you for this opportunity to testify. I will submit the remainder of my testimony for the record.

NIMH Research and Research Training

In 1986, the Office of Technology Assessment's background paper on children's mental health made special note of the inadequate support given to research into childhood mental disorders. The paper describes the current research situation in these words:

> For research related to children's mental health and for training clinical and research professionals in this area, the Federal Government is virtually the only source of funds... Some critics charge that the funds available to support mental health research are inadequate to take advantage of "exciting" research opportunities or even to foster rational development of the field. Research on childhood mental disorders is frequently used as a prime example of the opportunities that are missed.

The funds that are available for research into childhood emotional disturbances, such as developmental disorders of infancy, hyperkinetic behavioral and attention deficit disorders, and psychotic disorders, come from NIMH. And the $14 million decrease in research dollars that the Administration has requested is disappointing, considering the increased support Congress approved for FY 1987. By appropriating $249 million for research in FY 1987, Congress allowed the NIMH research budget to be equal with the research budgets of other health-related agencies. If research is not supported in FY 1988, major commitments to research into schizophrenia and the emotional implications of AIDS will be retarded or uninitiated. And the $20 to $30 million that has been carved out at NIMH in recent years for intramural and extramural research relating to children's mental illnesses cannot provide researchers with enough support to go after the "exciting" opportunities that are presented.

With prevalence estimates for children with emotional illnesses set at close to 12 percent, the funding for research into their special needs cannot continue to lag far behind research for physical disabilities.

The American Academy of Child and Adolescent Psychiatry recommends that NIMH research programs be funded at $330 million in FY 1988. The Academy also recommends an increase in research training program for FY 1988 to a level of $32 million.

Child and Adolescent Service System Program

One program that Congress has approved and expanded in order to counter this lack of services is the Child and Adolescent Service System Program (CASSP). Initially funded in 1984, with $1.5 million from the Community Support Program, CASSP began a federal support program for providing coordination in services to chronically emotionally disturbed children and adolescents. Eight states were given grants in the first round of funding, but 44 states and one territory had applied for assistance.

By FY 1987, CASSP had funded twenty-eight states and three local grants. The federal money has been supplemented in many of the states, and technical assistance has been provided for coordinating services from all appropriate state agencies. Members of the Subcommittee on Appropriations received a copy of the monograph developed by the CASSP Technical Assistance Center and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children, "A System of Care for Severely Emotionally Disturbed Children and Youth." The monograph is an example of the cooperation that has been fostered between the federal government and state government in the efforts to improve services for emotionally disturbed children, many of whom are either underserved or inappropriately served.

As CASSP moves to fund service coordination at the community level, the American Academy of Child and Adolescent Psychiatry recommends that Congress approve the full authorization amount of $24 million.

The support that Congress has given to research, training and services for emotionally disturbed children and adolescents is greatly appreciated. Because of the child psychiatrists yet to be trained, the research yet to be undertaken, and the services to be developed and coordinated, the Academy requests your support for these NIMH program appropriations.

STATEMENT OF HENRY WORK, M.D., NATIONAL CONSORTIUM FOR CHILD MENTAL HEALTH SERVICES

Dr. WORK. Thank you, Senator.

As a retired individual, I have been able to devote more time to cooking, so if you are really starving I am available. [Laughter.]

As a clinical professor of psychiatry at Georgetown and George Washington, I represent this consortium of some 19 organizations which has been going for 16 years now and trying to represent the organization of services for children, as well as the knowledge about them, the training that is needed to perform.

We are concerned about the child and adolescent service system program, to which Dr. Frazier referred earlier. It is a program that got started in 1984, as you know, and the amount that was available for the first year allowed us to do some pilot work under the Education for All Handicapped Children Act.

The important thing is that it has begun to coordinate services, so that all of the knowledge that people have been asking for and digging for can be brought to focus on the child who is in need of services.

The second year allowed 29 States to participate in this program, and we do hope that increased amounts of money can be given for increased coordination of these various programs.

A study of it made by the Georgetown Child Development Center pointed out that two-thirds of all severely emotionally disturbed children and youth in this country do not receive the services they need. Many others receive inappropriate care, not because of knowledge but because of a lack of application of knowledge to a continuum of services.

There is a complete model of care in the monograph from Georgetown, and it points out that all services have to be child-centered, with families involved and community based. And I think this is a critical item that needs support from your committee.

Senator DOMENICI. I did not hear your last statement, I am sorry. Would you repeat that?

Dr. WORK. The issue is that the services need to be family supported and family directed and child-directed, but they also need to be community-based. And there needs to be organization within services so that children get the full benefit of the knowledge that is available.

PREPARED STATEMENT

Therefore, we ask that the subcommittee continue support for this program in fiscal year 1988 to enhance the full range of services, because services given partially or fragmentedly do not do much for children. We are asking for $24 million for the Community Support Program and $7.8 million for the CASSP.

I thank you.

Senator DOMENICI. Thank you very much.

[The statement follows:]

STATEMENT OF HENRY WORK

The National Consortium for Child Mental Health Services appreciates the support that has been given to providing mental health services to children and adolescents during these difficult budget times. Congress has responded to Administration requests to eliminate critical National Institute of Mental Health programs, which encourage community support and clinical training, by voting to sustain them each year. The Consortium thanks you for believing in these programs and encourages you to continue watching the success they have in serving child and adolescent mental health services.

I am Dr. Henry Work, a former chairperson of the National Consortium for Child Mental Health Services. The Consortium was formed in 1971 to inform and promote understanding about the emotional disturbances of children under age 18, and the special services they require. The Consortium has 19 member organizations, which are listed at the end of this testimony. All of the members are national, consumer, professional and provider organizations. We meet quarterly to review the state of mental health service for children and to act on issues that need unity and national information and education strategies.

The Consortium members are concerned that the small gains and successes over the past few years not be lost in sweeping budget cuts. Their major concern is with the Child and Adolescent Service System Program (CASSP), a federal, state, community mental health program for severely emotionally disturbed children. CASSP has shown tremendous success since its approval in 1984. The Consortium also asks that the Subcommittee support National Institute for Mental Health programs in clinical training, research and research training, as well as the 1986 authorized protection and advocacy program.

Recommendations

Specific appropriations recommendations by the National Consortium for Child Mental Health Services for specific NIMH programs have been coordinated with other mental health advocacy and provider organizations and are as follows:

Community Support Program, including the Child and Adolescent Service System Program (CASSP)..........$24 million with $7.8 for CASSP

Clinical Training	$28 million
Research	$330 million
Research Training	$32 million
Protection and Advocacy	$11 million

Clinical Training

The Consortium also urges report language specifying the underserved population of children and adolescents and directing clinical training funds to be used for mental health specialists who care for children and adolescents.

Research

Research projects in childhood depression, developmental disorders, substance abuse treatment, schizophrenia and other major emotional disorders have been moving far more slowly than research into physical illnesses or adult disorders. As the 1984 Institute of Medicine report noted, "Research on disturbances as they form would provide a new perspective for understanding basic mechanisms and should markedly enhance early diagnosis and prevention efforts".

By supporting the NIMH programs which influence research, treatment and services for children and adolescents, Congress will underscore their recognition that many adult disorders originate in childhood, and that developmental delays experienced by children with untreated emotional disturbances force longer more expensive treatment in adulthood.

The Consortium appreciates the support that Congress has given in the past to children's mental health services. Its members urge you to renew that support in FY 1988.

Child and Adolescent Service System Program

In 1984, when the Child and Adolescent Service System was initiated with an appropriation of $1.5 million out of the Community Support Program (CSP), the commitment was for improved services for severely emotionally disturbed children and adolescents. The new service program was consist with the eligibility under the Education for All Handicapped Children's Act, and offered, in that first year, an opportunity for eight states to coordinate children's mental health services so that all eligible children received the full range of services, including mental health, health, education, child welfare, juvenile justice and others.

The second year appropriation of $3.9 million added to $4.7 million in FY 1986 and $7 million in FY 1987, has allowed 29 states to participate in the planning and implementation of a plan to improve service delivery for seriously emotionally disturbed children. This year three communities, within states that are well along in their service system development, were awarded grants, bringing the total number of funded projects to 31.

A careful system of evaluation is showing an increased coordination and provision of services for seriously emotionally disturbed children. This goal alone would suffice; however, the CASSP program has set additional goals which make this such an excellent example of federal, state, community and family involvement in helping children who need the widest range of services. Besides coordinating services, CASSP seeks to develop leadership for acquiring services, lay the groundwork for permanent collaboration among agencies, involve family members in the state and community program planning as well as planning that is done for individual children, provide technical assistance to the states and communities, and evaluate the entire process.

The technical assistance that has been provided through the Georgetown Child Development Center includes the development, and distribution of the monograph, "A System of Care for Severely Emotionally Disturbed Children and Youth," which members of the Subcommittee have received. The monograph accepts the reports that:

- two-thirds of all severely emotionally disturbed children and youth in this country do not receive the services they need,
- with many others receiving inappropriate care because the communities lack a continuum of services.

A complete model of a system of care is presented in the monograph with principles for service delivery and alternative system management approaches. States and communities can apply the model to their specific needs, making sure to include the core goals which require that the system of care be:

- child-centered, with the needs of the child and family dictating the types and mix of services provided, and

- community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

These core values support the related federal programs which the Consortium has defended and advocated since it was organized: Medicaid's Early, Periodic Screening, Diagnosis and Treatment Program, the Education for All Handicapped Children's Act, the block grant for maternal and child health, and the ADAMHA block grant.

The Consortium urges the Subcommittee to continue support for the CASSP program in FY 1988 in order to enhance the full range of federal services by offering states a means to coordinate them. By recommending an appropriation of $24 million for the Community Support Program, with $7.8 million for CASSP, the Subcommittee will allow approximately 10 to 12 additional states and/or communities to be funded. Each grant means better services for children who may not now be receiving any services.

The National Consortium asks this Subcommittee to support each of the NIMH programs that serve children's mental health. If we can provide any information regarding child mental health services, please contact the chairperson, Joseph Palombi, M.D., at 202/966-7300.

Members of the National Consortium for Child Mental Health Services:

American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Association of Children's Residential Centers
American Association of Psychiatric Services for Children
American Medical Association
American Orthopsychiatric Association
American Psychiatric Association
American Psychological Association
American Society for Adolescent Psychiatry
Child Welfare League of America
Children's Defense Fund
National Association of School Psychologists
National Association of State Mental Health Program Directors
National Center for Clinical Infant Programs
National Congress of Parents and Teachers
National Council of Community Mental Health Centers
National Mental Health Association
Psychiatric Adolescent & Child Treatment & Education Coalition
Society of Professors of Child Psychiatry

STATEMENT OF WILLIAM DEWEY, PH.D., ON BEHALF OF THE COMMITTEE ON PROBLEMS OF DRUG DEPENDENCE AND THE AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY

Senator DOMENICI. William Dewey, Committee on Problems of Drug Dependence and the American College of Neuropsychopharmacology.

Dr. DEWEY. Thank you, Senator. I appreciate the opportunity to be here today.

I am Bill Dewey, professor of pharmacology at Virginia Commonwealth University, and I am representing the American College of Neuropsychopharmacology, an organization made up of over 430 of the world's outstanding neuroscientists who are elected because of their significant contributions to our understanding of the functions of the brain and treatment of mental diseases, and the Committee on Problems of Drug Dependence, which is the longest standing scholarly research group in the world involved with this particular problem.

The two groups which I represent sincerely appreciate the leadership your subcommittee took in realizing the importance of research in the 1986 Anti-Drug Abuse Act and the report language and supplemental appropriation bill which inhibited OMB from decreasing by 50 percent the benefit which your efforts provided.

The scientific community has responded in a dramatic fashion. There are at least four times the normal number of research applications submitted as a result of the antidrug abuse bill. This represents a considerable effort by the scientific community.

My crucial message to you today, sir, is the importance of stability in the commitment of funding research in mental health and substance abuse. We have made some great strides, and you have heard from other speakers today, in recent years in our understanding of the brain and diseases of this organ.

Now it is time to continue, rather than to cut back, as proposed by the administration's budget. We know a great deal about heroin dependency and we can treat heroin dependency and heroin overdosage. We cannot do the same for cocaine or other abused drugs.

In addition, we have shown that a number of people who were mentally ill have been returned to productive lives. We do not have all the answers and we need to continue at this time.

The organizations that I represent have taken the initiative themselves. CPDD has organized a meeting this past January of the leaders in the world on cocaine research. Three important positions came out of that meeting:

One was that many young people who are apparently healthy have had heart attacks, myocardial infarctions, as a result of cocaine abuse. Pregnant women have trouble carrying the fetus to term if they use cocaine. And there are some interesting drugs that are useful in treating cocaine.

ACNP has established a task force to evaluate current knowledge of schizophrenia. This final document will be available in about 1 or 2 weeks. The document on the cocaine meeting has been attached to our official statement which has been submitted.

Both of these organizations concluded that stable sufficient funding is necessary to take advantage of the excellent opportunity that now exists to answer the important questions in the drug abuse area and in mental illness, including schizophrenia.

PREPARED STATEMENT

In conclusion, these two organizations endorse the recommendations of the Mental Health Coalition concerning the fiscal year 1988 budget of $330 million for NIMH, $183 million for NIDA, and $89.5 million for NIAAA.

Thank you very much, sir.

[The statement follows:]

Statement of William Dewey

Mr. Chairman and Members of the Subcommittee, my name is William L. Dewey. I am Professor of Pharmacology and Associate Dean at the Virginia Commonwealth University in Richmond.

I am speaking today on behalf of two organizations which share a concern about biomedical research on alcoholism, drug abuse, and the multiple forms of mental disorder -- the American College of Neuropsychopharmacology and the Committee on Problems of Drug Dependence.

The American College of Neuropsychopharmacology (ACNP) is an interdisciplinary organization concerned with research about biological function in the central nervous system and its relationship to the causes and treatment of mental and addictive disorders. Its membership consists of more than 430 research scientists elected to membership on the basis of recognized scientific contributions. The ACNP represents the moSt significant group of scientists in the United States involved in the research areas covered by the three component Institutes of the Alcohol, Drug Abuse, and Mental Health Administration.

The Committee on Problems of Drug Dependence (CPDD), of which I am Chairman-Elect, represents the longest standing group in the United States concerned with problems of drug abuse and has been in existence since 1929. CPDD is a distinguish multidisciplinary panel that is currently sponsored by ten professional societies, on which many of the most respected researchers in the area of drug abuse serve. CPDD has three primary functions: it provides a testing program to government agencies, industry and academia to determine whether drugs, be they new pharmaceutical products, drugs currently on the market, or street drugs, have the potential to produce dependency or are prone to abuse; it also holds the major annual meeting in the U.S. in the field of drug abuse; and it seeks to contribute to public information and the public debate on issues relating to drug abuse and dependency.

What CPDD and ACNP share is an awareness of the importance of biomedical research carried on at ADAMHA. Collectively, the impact of alcohol, drug abuse and mental health problems on our society is very large. The most recent estimates put the economic impact of the consequences of these problems at $249 billion. Most recently, Congress has been addressing the consequences of these problems, with billions of dollars to address drug abuse and homelessness.

CPDD and ACNP also share a sense of the opportunities currently available for research in mental health, and alcohol and drug abuse and dependence. In research on the brain, with the new technologies for observing the living brain, the discoveries that have been made about how the brain functions, and the availability of ways to probe genetic bases of susceptibility, the opportunities for major advances are upon us. Just in this last year, previous identification of opioid receptors in the brain have turned out to be the key to identifying how the AIDS virus enters the brain and for developing a potential new treatment for AIDS. Similarly, the identification of a genetic component to certain forms of manic depression has opened up a whole new area of understanding of serious mental illnesses.

In research on drugs of abuse, the message is how much remains to be learned. For heroin and other opiates, where research has been extensive over many years, a great deal is known. We know how these substances work on the brain; we know how to counteract overdoses; we know of pharmacologic treatments with new and potentially more effective treatments under study. But that can be said of no other drug of abuse, primarily because we have not devoted the necessary resources to research on these substances. Can you imagine how different it would be if we approached an epidemic like crack in the same way and with the same resources that the Centers for Disease Control approaches a medical epidemic, or the way we have approached the AIDS epidemic?

The bottom line is that the size of the research budgets at ADAMHA, compared with the nature and size of the problems, is small. This is in no way a criticism of this Subcommittee, which has been a leader in increasing research funding at ADAMHA during a time of overall severe financial restraint, and we are grateful, extremely grateful, for your leadership. But these are problems that rival cancer and heart disease in their impact, both human and economic, on our society, and yet the research budgets in total are but a fraction of what is spent on those diseases, and a fraction of the economic cost of mental illness and alcohol and drug abuse.

One need only look at the response that has been received to the dramatic increase in the funding for research at the National Institute on Drug Abuse in FY 1987 to understand the impact of increased funding. As of the end of April, there were nearly 700 grant applications pending in response to the $27 million in research funds made available as a result of the Anti-Drug Abuse Act of 1986, an overwhelming response not just from traditional drug abuse researchers but from the entire biomedical community. Increased resources will attract quality research in these fields.

There are two special initiatives that ACNP and CPDD have taken that we would like to report on, Mr. Chairman. First, in response to the interest in Congress about cocaine, CPDD, in conjunction with the American Society for Pharmacology and Experimental Therapeutics, sponsored a conference of experts on cocaine, which I organized, to put together a consensus on what is currently known about cocaine and to set forth directions for future research.

The result of this conference was the realization that in every aspect of knowledge about cocaine, there still remain many more questions than answers. How cocaine acts on the brain; what sorts of treatments are effective; what adverse effects result from short and long term useage, including effects on pregnancy and cardiac arrest; who uses cocaine, and what factors predict useage; the particular attributes and risks of crack -- all these questions remain to be answered. If I may, I would like to submit the results of this conference for the record. The summary of findings and recommendations for future directions for research on cocaine are contained on the last two pages of the document.

ACNP, in response to Congressional interest in opportunities in schizophrenia research, convened a special task force to draft a report on current opportunities for schizophrenia research The conclusions of the ACNP report are that for many reasons, including the fact that schizophrenia has been a harshly stigmatizing disease, there has not yet developed an adequate funding base or infrastructure for research in schizophrenia, and that, as a result of many advances in the last twenty years, the time is right for a major investment in the study of this disease syndrome.

Areas of promise for understanding the causes and underlying mechanisms of the disorder include genetics, nongenetic influences including prenatal and perinatal factors, immunology, imaging research, the mechanisms for regulation of brain stability, treatment, including antipsychotic drugs and how those drugs work, and the role of psychosocial treatments.

The report makes recommendations for research mechanisms required to encourage schizophrenia research. In brief, there is a need to establish mechanisms for long-term support of research in this area. Given the complex, multi-faceted disease syndrome, the usual 3-year research mechanism puts schizophrenia researchers at a disadvantage, because research in this area cannot produce quick, short-term results. Unless mechanisms to provide longer-term support are put into place, there will continue to be a disincentive for researchers to enter the schizophrenia field.

In sum, Mr. Chairman and Members of the Subcommittee, the opportunities for research at ADAMHA are there, the interest is there, and the most pressing requirement is for funding. We endorse the recommendations of the Mental Health Liaison Group, which call for research budgets of $330 million in FY 1988 for the National Institute of Mental Health, $183 million in FY 1988 for the National Institute on Drug Abuse, the true current services figure, and $89.5 million for the National Institute on Alcohol Abuse and Alcoholism. In addition, we endorse the recommendation to increase the funding for research training at the Institutes to $32 million in FY 1988. Unless we provide sufficient encouragement to young researchers to enter the ADAMHA fields, we will not have the young, up and coming researchers necessary to sustain progress in these fields.

I thank you for this opportunity to appear before you, and I especially thank you for your outstanding leadership in the past in providing funding for biomedical research to address the crucial problems relating to mental illness, and alcohol and drug abuse and dependence.

SCIENTIFIC PERSPECTIVES ON COCAINE ABUSE

Sponsored by

American Society for Pharmacology and Experimental Therapeutics

and

Committee on Problems of Drug Dependence

INTRODUCTION, BIODISPOSITION, AND DETECTION IN BODY FLUIDS

Cocaine is derived from plants grown in the Western Hemisphere, where it has been used for hundreds of years by South American Indians in the Andes. In addition, it has a long history of therapeutic use as a local anesthetic. It is currently a major drug of abuse in the U.S. The discussion in this paper will relate solely to the use of cocaine as an abused substance. The problem of cocaine abuse continues to grow despite evidence that abuse of other drugs in the U.S. peaked in 1979 and has subsequently declined slightly. Exact estimates of the number of users of cocaine are difficult to determine, but most experts agree that literally millions of persons use the drug regularly. Many aspects of cocaine abuse are controversial or not well understood. Therefore, the goal of this conference was to summarize what is known about this important drug and to indicate areas where future research is needed.

Cocaine, an alkaloid from the plant Erythroxylon coca, is highly lipid-soluble; but the hydrochloride salt is water soluble. Traditional use of the drug by Indians of the Andes is by chewing the leaves with an alkaline material which facilitates absorption of the base through oral mucous membranes. This route of administration provides a steady supply of cocaine to the brain which is maintained for hours.

In the U.S. and other developed countries the preferred route of administration is by sniffing the hydrochloride salt, with absorption through the nasal mucous membranes. By this route, the local vasoconstricting effects of the drug slow absorption and prolong the effect as compared to other routes such as smoking. The drug can also be taken orally, but this is rarely done as large quantities of the drug would be required to provide a desired effect. In addition, cocaine has been self-administered intravenously, though far less often than in the case of heroin. As many now recognize, a growing fashion in recent years is to smoke cocaine. However since the hydrochloride salt of cocaine will be volatilized only at temperatures which degrade it, smoking is only possible after cocaine is converted by a chemical process to the alkaloid, so called "free base" or "crack", which is readily volatilized undegraded at much lower temperatures. Both intravenously administered and smoked cocaine reach the brain within seconds with high concentrations achieved almost immediately. Thus, these two routes produce more immediate and intense effects.

As is the case with most centrally-acting, lipid-soluble drugs, cocaine has a large apparent volume of distribution. The drug is quickly metabolized, leading to a relatively short half life of 30-90 minutes. The half life of the two principal metabolites, ecogonine methyl ester and benzoylecogonine are in the range of 4 to 6 hours, respectively. The longer half-lives of these inactive metabolites, which are excreted in urine, provide a basis for forensic testing of most cocaine users since only minute amounts of cocaine are excreted unchanged.

A variety of immunoassays are available for detection of cocaine and its metabolites in body fluid, including both radioimmunoassays and non-isotopic assays of a variety of types. Gas-liquid and high performance liquid chromatography can also be used for analytic purposes. The most reliable confirmatory assay is gas chromatography/mass spectrometry. The usual urine test detects the benzoylecogonine for approximately one to three days, depending on the dose of cocaine used, whereas cocaine itself is detectable for only a few hours after use. None of these tests for drug metabolites can be interpreted as indicating the precise time of drug intake, the dose of drug taken, or the magnitude of the effect.

EPIDEMIOLOGY AND PREVENTION

Progress in the area of epidemiology has occurred primarily in five areas: (1) surveillance of the experience of the U.S. population with the use of cocaine; (2) estimating the chances for beginning cocaine use, for stopping use, and for continuing use; (3) identifying population subgroups that are more vulnerable to cocaine use; (4) identifying conditions under which cocaine use is more likely to occur; and (5) evaluating public health consequences of cocaine use.

Current surveillance activities include the Drug Abuse Warning Network (DAWN), supported by the National Institute on Drug Abuse. This surveillance system shows continuing increases in the prevalence of cocaine use among patients seen in emergency rooms and among drug-related deaths. Surveillance also includes the periodic national household surveys and high school senior surveys, also supported by NIDA. Data from these surveys indicate that for some subgroups in the nation, the prevalence of use continues to increase. However, in other subgroups, the increase in prevalence of cocaine use during the 1970's has been followed by a levelling of prevalence. This is true for the age group 18-25 in particular. Changes in occurrence of new cocaine use (initiation) and changes in the duration of use are the forces driving these prevalence values, but the relative contribution of these factors remains unclear.

Several steps would strengthen the surveillance efforts: (a) more thorough evaluation of the validity and precision of the epidemiologic measurements, especially in the assessment of the circumstances of use, such as the route of administration; (b) more thorough analysis of the data to reveal inter-community, intra-community, and subgroup variation in cocaine use and cocaine problems, and (c) greater use of prospective research strategies, by which the surveillance samples are studied over time with periodic follow-up measurements. These steps will increase knowledge on the continuing emergence of free-base/crack smoking in the population.

By following population samples over time, prospective epidemiologic studies show that the chances for initiation of cocaine use persist and increase well into the child-rearing years of adulthood. By contrast, the chance of initiating the use of marijuana, LSD, and other controlled substances appears to fall to very low levels by age 24. The population groups that seem more vulnerable to cocaine use include youths and young adults who have higher than average pre-existing levels of tobacco, alcohol, and especially marijuana use. Because youths with conduct problems in early elementary school have higher risks of becoming heavy marijuana users, it is anticipated that these youths also may be more vulnerable to initiating cocaine use.

By studying what cocaine users themselves report about their problems and the hazards of cocaine use, epidemiologic studies have quantified the extent to which daily users of cocaine are more likely to experience cocaine hazards. As expected, use of cocaine on a daily basis is substantially more hazardous than experimentation or infrequent use.

Steps to strengthen and add to these advances will include: (a) thorough study of the conditions and processes by which there is diffusion of cocaine use through communities and populations, and the conditions under which cocaine use begins; (b) study of the course of cocaine use, from initiation until cessation of use; (c) thorough examination of the observed relationships between cocaine use and concurrent or antecedent use of tobacco, alcohol, and marijuana, as well as the early behavioral profiles of conduct problems; and (d) more intensive epidemiologic and causal analysis of suspected cocaine hazards.

Important advances in epidemiology can be made simply by extending current field studies of tobacco, alcohol, and marijuana use to include the assessment of cocaine use, behavioral dependence on cocaine, and other hazards of cocaine use. Furthermore, some of these current field studies are preventive trials that can tell us whether incidence of cocaine use is affected when we change the early behaviors, or reduce antecedent levels of tobacco, alcohol, and marijuana use.

To be effective, prevention of illicit cocaine use and cocaine problems should be based on results from prospective and longitudinal epidemiolgic studies on the developmental paths leading to cocaine use and non-use. Much is known now about conduct problems and other early behavioral responses of children that predict later alcohol, marijuana, and tobacco use. We do not yet know whether these early predictors hold for cocaine use specifically.

Preventive trials are now in place to test whether we can reduce the chances of later tobacco, alcohol, and marijuana use by reducing early conduct problems. Longitudinal follow-up will be needed to examine whether occurrence of cocaine use is affected by these preventive efforts. In addition, longitudinal follow-up in populations previously studied also will yield vital information on these and other developmental paths toward cocaine use.

At present most drug abuse prevention efforts are targeted toward all children or youth in a particular age group (for example, Project SMART). An alternative is to identify groups that are more vulnerable to problem behavior such as illicit drug use and to design preventive interventions specifically targeted at the vulnerability factors. The intervention can be focused on the priority groups only, or on the larger population. The more that is known about developmental vulnerability markers, however, the more specific prevention programs can be.

Knowledge of early predictors that indicate which groups of individuals are at risk can be gained by supporting epidemiologic studies of defined populations, such as age cohorts of young children in specific neighborhoods or communities. Early behaviors and conditions can be measured as children enter school, or even before, and preventive trials can then be directed at conditions identified to place children at risk for involvement with substances. To carry out such studies, adequate control groups are needed and community leaders must be enlisted and involved, so that children will participate in rigorous tests of preventive interventions.

Such longitudinal research must address the following questions:

1) What are the early predictors of a) the initiation of use; b) the repetition of use; c) the maintenance of regular use; and d) the resumption of "normal" functioning following termination of use?

2) What are the specific interventions which affect factors contributing to each of the aforementioned stages of drug involvement?

3) In what ways does cocaine reflect involvement of individuals in other health-compromising behaviors, e.g., use of other substances, promiscuous and/or unprotected sexual intercourse, reckless driving?

4) What are the situational factors within families, schools, and communities which support the implementation and effectivenss of specific preventive interventions?

To answer these questions, several related research directions should be initiated. First, we must undertake longtudinal prospective communtiy-based studies of cocaine use in the population. Second, we must undertake more analyses which inform us of the biology, psychology and sociology of the initiation, continuation, maintenance and cessation of cocaine use. Specifically, we must develop an understanding of factors leading to a decision to use or not use and how individual and environmental elements lead to that outcome.

In addition, we must support researchers currently involved in relevant field-based trials to focus as well on cocaine issues. This step is warranted both for reasons of economy and science. Finally, we must continue ongoing efforts to follow promising leads about causal precursors (e.g., the increased risk for substance abuse of children who manifest social and conduct problems in the primary grades) and enhance the scientific payoff of these efforts by maximizing the timely exchange of information and the capacity to plan and carry out long-term studies of these problems.

NEUROCHEMISTRY AND ELECTROPHYSIOLOGY

Cocaine is a powerful stimulant with positive reinforcing actions. With continued use, the qualitative nature of the stimulation changes, leading to a variety of behavioral changes that often are less pleasurable and are characteristic of the cocaine-dependent state. The mechanism for these effects and the sites in the brain are complex and not completely understood.

Many drugs of abuse, including cocaine, opioids, and ethanol, appear to have actions upon monoamine neurons; in particular, interactions with mesolimbic and meso-cortical dopamine systems have been implicated as important sites of action that are involved in the "rewarding" effects of such drugs.

Cocaine blocks the presynaptic uptake of norepinephrine, serotonin and dopamine, an action shared by the antidepressants and amphetamines. However the affinities of these agents for the presynaptic neurotransmitter transporters differ. Amphetamine and cocaine exhibit similar behavioral effects, yet their neurochemical actions differ in many respects. For example, amphetamine releases presynaptically stored monoamine transmitters, an action that may not be shared by cocaine.

Cocaine has a powerful inhibitory effect upon many monoamine-containing neurons in brain regions such as the locus coeruleus, ventral tegmental area, and raphe nuclei. This appears to reflect the ability of cocaine to increase the concentration of monoamine transmitters in the extracellular space surrounding the cell body and dendrites resulting in autoinhibition of the spontaneous activity characteristic of many of these neurons. In addition, local anesthetic actions occur in a dose range well above that required to potentiate catecholamine actions; nevertheless, at least in some cases, blood/brain levels of cocaine approach local anesthetic levels, and a convulsant effect may be seen.

These actions are primarily those seen with acute administration. Repeated administration of cocaine is associated with adaptive changes, such as an altered monoamine receptor density, and levels of biosynthetic enzymes. The neuronal plasticity of the brain may account for chronic behavioral effects of cocaine including behavioral sensitization to some effects, tolerance to others and the behavioral pathology seen in chronic cocaine abuse.

We need a clearer understanding of the acute and chronic effects of cocaine on the function of the nervous system with special reference to the monoamine systems, including the levels of the monoamines, their synthesis rates, the enzymes involved in synthesis, the turnover of monoamines, and the electrical activity of the catecholamine and serotonin neurons themselves. More information is also needed on the specific alterations in receptor density and function associated with chronic cocaine administration. We need to identify the specific target neurons where increased receptor density develops with repeated cocaine use. The newly established techniques of autoradiography and computer-assisted image analysis of dopamine and other receptors will permit definitive answers to these questions in the near future.

We need to know more precisely what the differential effects of cocaine are on the different dopamine systems which subserve different behaviors. Are there differences in the responses to acute and chronic cocaine in terms of monoamine metabolism, receptor density and electrical activity, in each of the discrete dopamine systems in the brain?

We are now able to identify binding sites for [^{3}H]-cocaine in the brain. With this approach, we should be able to determine the density and distribution of [^{3}H]-cocaine binding sites in various brain regions, and their relationships to the dopamine, noradrenergic and serotonergic systems, and we ought to be able to determine whether these binding sites are modified after acute and chronic cocaine administration.

A comparison of the neurochemical effects of cocaine with those of other amine uptake blocking agents and of the similarly acting psychomotor-stimulant amphetamines will also be of great importance to our understanding of positive reinforcement, reward mechanisms and cocaine abuse. What are the behavioral and neurochemical effects of acute and chronic administration of cocaine, of selective dopamine uptake blockers, of selective norepinephrine uptake blockers, and of selective 5-HT uptake blockers, administered acutely and chronically, either alone, or in combination with cocaine?

A better understanding of the role of GABA neurons in the action of cocaine and in behavioral sensitization, particularly the kindling phenomenon and the enhanced susceptibility to convulsions, is desirable, and may lead to novel approaches to the therapeutic management or prevention of some of these phenomena. In addition, a greater knowledge of the effects of cocaine on neuropeptide-biogenic amine interactions in the brain may lead to additional insights into the actions of cocaine and the management of cocaine abuse. We need to develop a better understanding of the neurobiological basis of reward, of tolerance, and of psychological and physical dependence.

We should learn more about cellular interactions between ethanol and other drugs of abuse and cocaine. Do ethanol or other drugs of abuse a) block acute effects of cocaine, b) facilitate the cellular actions of cocaine, c) block the development of sensitization, or d) block the "sensitized" response to cocaine? Can prior experience with ethanol and other drugs of abuse modulate subsequent sensitivity or responsiveness to cocaine? Is there any kind of drug-reward contingency learning involved?

In order to mimic the adverse patterns of cocaine use among cocaine abusers, these studies must be performed with different protocols and durations of cocaine administration, including both long-term, continuous, and intermittent.

BEHAVIORAL PHARMACOLOGY

An analysis of the environmental, behavioral and pharmacological interactions that determine both the conditions of occurrence and the consequences of drug taking has significantly advanced the assessment of cocaine's abuse liability and dependence potential. The self-administration model has provided ample evidence for the reinforcing efficacy and toxicity of cocaine, predicting severe abuse potential, and supporting claims that cocaine is among the strongest of drug reinforcers. Cocaine's impressive strength as a reinforcer is reflected in the generality that characterizes the available data both across and within species. The data indicate that cocaine intake can be regulated under limited access conditions, but can become uncontrolled, producing severely debilitating consequences under unlimited access. These potent reinforcing effects appear to involve the participation of neuronal circuits that mediate "reward systems".

Investigations of self-administration of cocaine in humans has allowed measurement of behavioral and physiological effects in a dose-dependent manner under conditions of actual use. Furthermore, these same studies have revealed a dissociation between drug intake and self-reported drug effects. These models thus provide an appropriate methodology for assessing different routes of administration and evaluating potentially useful therapeutic interventions.

Measures of performance following cocaine administration reveal little change, although performance deterioration due to boredom or fatigue can be partially attenuated. Concurrent electrophysiological measurements do, however, indicate a decrement in selective attention and resources available for stimulus processing after cocaine administration. Such effects can interfere with acquisition of new behaviors. In contrast, self-reported behavioral facilitation is reflected in perceived enhancement of mood and performance. Social facilitation (e.g., increased talkativeness, friendliness and activity) enhances the popularity of its use.

One of the most important contributions of research on cocaine has been the demonstration that behavioral and environmental conditions play a prominent role in determining the character and extent of its effects. In addition, substantial data exist suggesting the important role of these factors as possible determinants of individual differences in drug taking and its effects. Such hypothesized relationships demand focused research into the role of contextual variables and their contributions to vulnerability to uncontrolled drug use.

We know virtually nothing about the effects of cocaine self-administered via the inhaled route. This route of administration, which has an onset of action as rapid as the intravenous route, but does not have the same problems, is a popular way to abuse cocaine. Carefully controlled studies in humans comparing the effects of cocaine when it is inhaled with the extensive database already available for the intravenous route will provide sorely needed information relevant to treatment.

It is clear that users claim improved performance after cocaine use. Does it, like amphetamine, provide that "small edge", bringing performance deteriorated by boredom or fatigue back to baseline levels? Or does cocaine in fact have a positive effect on performance? Does it distort judgement, providing the user with a false sense of confidence, or does cocaine in fact facilitate performance in ways that have not yet been evaluated? Further research into the performance-potentiating and debilitating effects of cocaine is a most likely area to shed light on why people use this drug, and also may well contribute to our understanding of its toxicity.

Many potentially useful therapeutic interventions have been suggested for the out-of-control cocaine user. In general, justification for their utility has been minimal, based on anecdotal reports of possible antagonism of hypothesized neurotransmitter roles. These potentially useful interventions should be tested under carefully controlled laboratory conditions, using the human self-administration paradigm, where both self-administration behavior and physiological and behavioral effects are monitored, so that careful evaluation of the full range of their interactions can be carried out.

Although an abundance of data exist supporting the extraordinary reinforcing properties of cocaine, little systematic data have been collected comparing cocaine to other drug reinforcers. There are currently minimal data, other than those collected with psychomotor stimulant drugs, validating the predictive power of the complex self-administration procedure and comparing different classes of drugs.

A very limited amount of research has been carried out investigating individual differences in responses to drugs. There are now abundant data indicating that history and current environmental and behavioral variables, as well as pharmacological variables, all play a part in determining drug effect, including both reinforcing properties and toxicity. This is an important area for continued research, both with non-human and human research subjects under a range of laboratory and more naturalistic conditions where both individual behavior and social interactions can be examined.

ADVERSE EFFECTS

We know a lot more about the residual toxicology of long-term amphetamine use than we do about these effects with cocaine. One of the most significant consequences of cocaine abuse is the development of behavioral pathology in chronic users. In its most extreme form, a cocaine psychosis, requiring hospitalization and treatment, can be produced. More subtle changes in behavior and personality also often result from cocaine abuse. This may include profound irritability, misperceptions, paranoid thinking, impaired interpersonal relations, and disturbances of eating and sleep.

A growing body of circumstantial data suggests that cocaine is capable of causing acute myocardial infarction, even in patients with normal coronary arteries. Further basic research is required to define the pathogenetic basis of this apparent relationship. The basis for sudden unexpected death unassociated with myocardial infarction in cocaine users remains undefined. Preliminary data suggest that such cases of sudden death may be due to ventricular arrhythmias. These arrhythmias may be the result of a direct effect of cocaine on the cardiac conduction system or an indirect effect that is mediated via cocaine's effect on the central nervous system.

Cocaine use appears to result in myocarditis in certain individuals. This apparent consequence of cocaine has been recognized only recently. Experimental investigations are required to both understand the pathogenetic basis for this relationship and characterize the histologic and ultrastructural findings associated with this complication of cocaine abuse.

Finally, it is likely that intensified surveillance of patients presenting to emergency rooms with acute myocardial infarction – including obtaining a history of drug use and medical problems as well as an analysis of blood and urine for cocaine and cocaine metabolites – will provide useful documentation regarding the prevalence of these cocaine-related cardiac events. The results of such surveillance may also provide data regarding the appropriate emergency room therapy for acute cocaine toxicity; standard therapy for such acute toxicity has yet to be defined.

We do not yet know all the determinants of variability in cardiac toxicity. In contrast, there is no variability in the behavioral effects in the same person. These facts add to the risk of abuse of this drug since it is such a powerful reinforcer.

We need to know more about:

1). What are the exact patterns of toxicity that present in emergency rooms. We need research on how acute toxicity should be treated.

2). How is the toxicity of cocaine altered by the simultaneous administration of other abused drugs, therapeutic agents and other intercurrent illnesses?

3). Does cocaine cause coronary spasm?

4). What are factors responsible for the development of cocaine-induced electrical instability leading to fatal arrhythmias?

5). How does cocaine cause myocarditis?

6). Are there any cardiovascular pathologic findings that are specific for cocaine?

Chronic cocaine use may cause significant alterations in a variety of other physiological functions and also may be toxic to other specific organs or tissues. Preliminary evidence suggests that the venoconstrictive and venoocclusive effects of cocaine may result in damage to the gastrointestinal tract and renal and pulmonary systems. Further study of potential toxicity to these and other organ systems is needed.

PERINATAL ADVERSE EFFECTS

It has been clearly shown that cocaine crosses the placenta via simple diffusion and rapid penetration of mucosal membranes due to its high lipid solubility, low molecular weight, and low ionization at physiological pH. Disposition of cocaine in pregnant and nonpregnant mice is in highest concentration in the uterus, followed by the placenta, spleen, kidney, fat, liver, lung, brain, spinal cord, heart muscle, eye and plasma. The vasoconstrictive property of cocaine has been shown to retard its penetration into the fetus in that fetal organs have one-fourth to one-third of the amount found in maternal brain and liver. Evidence in mice and ewes suggests that the altered hormonal balance in pregnancy may cause increased tissue accumulation and/or decreased breakdown of the drug. In pregnant ewes, a dose-response effect has been shown with regard to the pharmacological effects of cocaine on pregnancy. Results reveal the following: decrease in uterine blood flow, increase in uterine vascular resistance, and reduction in fetal oxygen levels.

Cocaine's pharmacological actions contraindicate its use in pregnancy. The vasoconstriction, tachycardia, and increased blood pressure caused by cocaine all increase the chance for intermittent intrauterine hypoxia, preterm labor, precipitous labor, and abruptio placenta, followed by hemorrhage, shock and anemia. Data from clinical populations provide further evidence of problems in children born to cocaine using mothers.

More research is essential to further evaluate cocaine's effect upon the perinatal period, the infant and the child. The following summarizes these issues:

1). Maternal medical and obstetrical complications need further delineation with reference to nutrition, disease entities and appropriate treatment regimens.

2). There is a need to develop epidemiological studies in order to determine if cocaine exposure in-utero influences formation of congenital malformations in infants.

3). By clinical and ultrasound measures, the effects of cocaine upon brain growth and brain pathology must be evaluated.

4). Extensive epidemiological studies, in several centers, should determine the potential influence of cocaine exposure in-utero upon the incidence of Sudden Infant Death Syndrome and the need for evaluation of the infants with regard to cardiorespiratory status and the necessity of cardiorespiratory monitoring.

5). The neurobehavioral outcome of neonates exposed to cocaine in-utero via clinical measurement scales such as abstinence scoring and the Brazelton Neurobehavioral Scale need more precise definition.

6). The potential long-term developmental effects upon the infant and child having been exposed to the pharmacological effects of cocaine in-utero must be further delineated.

7). Psychosocial situations with regard to parenting abilities and child protection in cocaine abusing families must be evaluated.

NEUROENDOCRINE EFFECTS

From this consensus conference, there is an evident paucity of data concerning the effects of acute, and of especial importance, chronic cocaine exposure on neuroendocrine and endocrine function, both in appropriate animal and organ perfusion in vitro models, as well as in clinical research. In studies of other drugs of abuse, it has been shown that neuroendocrine and endocrine function, specifically function of the hypothalamic-pituitary-adrenal axis and hypothalamic-pituitary-gonadal axis, may be significantly altered by acute and chronic use of drugs (e.g. ethanol and short-acting opiates). These alterations include effects on neuropeptides which are releasing hormones or regulating hormones, as well as on steroid hormones produced peripherally. Studies of certain spontaneous human psychiatric disorders have been shown to be associated with disruption of endocrine function of similar types. Thus studies during effective treatment of cocaine abuse should include studies of neuroendocrine function in that setting. Feedback control mechanisms involving endogenous opioid systems are also altered by drugs of abuse such as short-acting narcotics, e.g., heroin, and parallel effects may be observed during cocaine abuse. Such studies of cocaine effects on endocrine and neuroendocrine function are important both from a standpoint of developing an information base on the toxicities of cocaine, and from the standpoint of understanding the addictive disease of cocaine dependency.

Studies of reproductive endocrinology are needed with respect to cocaine abuse, and also treatment for cocaine abuse. Reproductive function is obviously preserved during chronic cocaine abuse (vida infra) but it is not known whether or not to a normal extent. Studies of the combined use of cocaine with other psychoactive agents on endocrine and neuroendocrine function are also of importance. These are the most prevalent combined use patterns of potential significant physiological and pathological importance in humans.

The possible relationships of one or more of the endogenous opioid systems to the reward systems and to the positive reinforcing properties of drugs of abuse are not well defined. These include the well-known positive reinforcing properties of cocaine. These relationships need to be explored both in appropriate animal models and in human studies, and need to be related to other effects of cocaine on neuroendocrine and neurotransmitter systems.

TREATMENT

Reconceptualization of Cocaine as Causing a Physiological as well as Psychological Dependence

Clinical experience with cocaine has helped to change the way we view cocaine dependence. Once viewed as only a psychological habit, because there was no dramatic opioid-like withdrawal syndrome, we now recognize that compulsive drug taking behavior may involve both acute and protracted biochemical alterations of the central nervous system and subtle withdrawal phenomena, both of which interact with highly reinforced behaviors and environmental cues to elicit severe craving. Such a reconceptualization has opened the ways to explore new treatment approaches and the withdrawal process itself. It has been noted clinically that the transition from low dose, intermittent cocaine use to high dose frequency use often leads to the residual addictive state.

Pharmacological Treatment Approaches

Our improved understanding of the physiological basis of cocaine addiction has led to a search for pharmacological treatment methods that could be combined with innovative psychological and behavioral interventions. The most focused efforts to date have focused on the dopaminergic system and the tricyclic antidepressants (TCA's). Promising agents in this regard have included tricyclic antidepressants such as desipramine and imipramine as well as dopamine agonists such as bromocriptine and amantadine. Neurotransmitter precursors have also been tried with some success. All these need further trials. Lithium and methylphenidate have only been found useful when specific psychiatric diagnoses for which they are appropriate are present.

Description of the Stages of Cocaine Withdrawal

Previously, cocaine withdrawal had been commonly viewed in a broad, undifferentiated fashion. Clinical research has delineated a phenomenon in which there are a number of phases. This differentiation opens the way for more specifically targeted treatment interventions.

Psychological Treatments

Although psychological treatment approaches make up the majority of methods used today to treat cocaine abuse, very little research has been done to examine their effectiveness. One of the few methods which has been examined experimentally is contingency contracting, which appears to be of use in the early phase of treatment in selected patients. Supportive methods such as counseling, group therapy, lifestyle change training, exercise and self-help groups such as Cocaine Anonymous seem helpful, but have not been studied experimentally. The same holds for specific relapse prevention training and psychodynamic treatment approaches that examine the role of cocaine in the patient's life.

The Role of Psychopathology in Cocaine Abuse and Dependence

A number of centers have found a high incidence of psychopathology in cocaine addicts seeking treatment, especially affective illness. While it is not always clear whether such findings cause or follow cocaine use, it has been noted that when specific pharmacotherapy is tried, there has been an amelioration both of the psychiatric disorder and of the cocaine use.

Future Directions for Treatment Research

Specific Treatment Approaches and Outcome

We must assess the relative efficacy and importance of various treatment approaches used alone and in combination with one another. Efficacy evaluations should be based on measures of treatment retention, and followup extending for at least one year after treatment termination. Special attention should be paid to the issue of patient treatment matching to determine which therapeutic approaches work best for different subgroups of patients who may differ with regard to such variables as severity of drug abuse and psychiatric diagnosis. Our studies should include evaluations of: inpatient vs. outpatient treatment, individual vs. group treatment, and self-help vs. professional treatment. We must also evaluate the importance of: family involvement in treatment; educational and didactic interventions; urine surveillance; and a requirement of partial vs. total abstinence. Data from such studies are needed to develop a logic for deciding when to intervene at all, when to hospitalize and for how long.

Acute and Protracted Cocaine Withdrawal

Recent research has described cocaine withdrawal as consisting of sequential phases. During the second phase which follows the acute "crash", there is a return of craving as well as dysphoria, fatigue, irritability and absence of pleasurable feelings from normal activities. Independent replication of these observations is needed as well as better understanding of the biological and environmental factors that determine the duration and severity of the symptoms in each phase. Such knowledge is critical for the development of rational interventions and more cost-efficient methods of management. The duration and etiology of the more subtle manifestations of the third protracted phase, which is associated with waxing and waning of craving also needs study.

Behavioral and Psychotherapeutic Approaches

There are virtually no controlled studies of the effectiveness of behavioral interventions or psychotherapy for cocaine dependence. Contingency contracting deserves objective evaluation since, in essence, the context in which much urine testing is done is tantamount to an implied contract in which negative consequences follow a positive test. Relapse prevention strategies that make use of both peer support and learning principles, and directed at avoiding cues and situations which elicit conditioned craving and withdrawal and developing better coping skills have proven useful in reducing relapse in opioid dependence. Carefully controlled trials are needed to determine the efficacy of such procedures in cocaine dependence. Psychotherapy can improve the prognosis of opioid dependent individuals with severe psychopathology. Similar research is needed in the case of cocaine dependence.

Pharmacological Treatment

In order to improve pharmacological treatments, explorations of the residual neurotransmitter-neuromodulator states following cocaine abuse is critically needed. Such effects may prolong extinction and impact on conditioned responses and sensitization. The development of a systematic knowledge base of agonist/antagonist effects mediating these long-term effects would increase the likelihood of successful pharmacotherapy. In addition to antidepressants and other agents already mentioned, novel approaches such as presynaptic dopamine modulators, neuropeptides, and sodium and calcium channel blockers and various combinations require exploration. Assessment of the toxicity of combinations of cocaine with some potential therapeutic drugs may need to be carried out in animals before trials in humans.

Role of Psychopathology and Psychiatric Symptoms

Better diagnostic tools need to be developed to help determine when psychiatric symptoms represent psychiatric syndromes which existed prior to cocaine use (and may therefore play some role in causing cocaine use and dependence) and which symptoms represent consequences or complications of cocaine use. A better understanding of the nature and duration of the biochemical changes induced in the human nervous system by chronic cocaine use will be critical to this effort. Such an understanding may also help in predicting what kinds of specific treatments of psychiatric symptomatology that might help to prevent relapse. However, determining the efficacy of such specific treatments will require controlled clinical studies in a variety of treatment settings.

SUMMARY STATEMENT OF THE CONFERENCE ON THE SCIENTIFIC PERSPECTIVES OF COCAINE ABUSE

The abuse of illicit drugs in the United States peaked in 1979-1980. With one exception, there has been a small, gradual decline in the abuse of these drugs. The exception is cocaine. In addition, a new form of the drug, the free base "crack", has appeared in the illicit marketplace. This form of the drug is being taken by a different method, smoking, rather than intranasally, i.e. snorting. By this route of administration, the cocaine is very rapidly and completely absorbed, and goes more directly to the brain leading to a more intense and less controllable "high". Parallel to the increasing use and new way of taking the drug, there has been a three- to four-fold increase in reports of adverse medical problems associated with the use of cocaine. These facts have aroused considerable concern among the scientific community. This concern prompted the American Society for Pharmacology and Experimental Therapeutics and the Committee on Problems of Drug Dependence to sponsor a meeting of biomedical experts to discuss our current knowledge concerning cocaine use and abuse and to outline future research to provide better methods for the treatment and prevention of cocaine abuse. The major findings of the participants of this conference are summarized below:

Cocaine is the most effective reinforcing drug we know. It produces intense drug taking behavior in all animal species studied, including man. There is a widespread feeling that cocaine produces improved performance. Laboratory studies in animals and man consistently have been unable to confirm this belief, except under conditions where performance decrements occur because of fatigue. Indeed, there is good evidence that cocaine produces a disruption of attention. Furthermore, the elevation of mood of a single dose does not reflect the effects of repeated administration. Chronic use can lead to severe depression and "cocaine psychosis." High doses can lead to seizures. The specific mechanisms involved with cocaine-induced seizures require further investigation. There is evidence that heart damage, such as myocardial infarction, associated with cocaine use is being seen more frequently. Additional research is needed to more fully characterize this phenomena which appears to occur even in healthy young subjects with no prior history of cardiac problems. We have much to learn about the acute and chronic toxicity of cocaine and are recommending a major effort in this regard. This would include the study of effects on organs such as the heart, lungs and brains, as well as possible long lasting behavioral changes, particularly after administering the drug by inhalation. Since there is an increasing use of the drug among young people there is a great concern about the future health of these individuals. Prospective epidemiological studies are needed to follow these young people into adulthood. There is emerging evidence that cocaine taken during pregnancy has adverse effects on the course of gestation and the fetus. Specifically, difficulties in carrying the baby to term and low birth weight are seen. Additional research is needed to determine the extent and consequences of the abnormal problems.

On the more positive side, cocaine is a drug which is proving to be an important tool for scientists involved in investigating the normal and abnormal function of the brain. It is hoped that the rapidly advancing field of neuroscience will provide information which will allow more rational design of effective treatments for cocaine and other drug abuse problems. The same might be said of the rapidly advancing field of drug abuse epidemiology. For instance, the finding that groups such as overly aggressive and/or shy children are more vulnerable to cocaine abuse, will lead to more specific targeting of prevention and treatment modalities. It was reported at this meeting that the drug desipramine, a therapeutic agent to treat depression, decreased cocaine use but not the craving for cocaine. These studies lend encouragement that a treatment modality can be found for compulsive cocaine abuse.

It is obvious that we have much to learn about cocaine action and abuse. We recognize that the economic rewards of supplying the illicit market make solution of the cocaine problem by interdiction of drug supplies very difficult. This makes it even more important to devote appropriate resources to research and prevention which have an impact on demand. Therefore there is an urgency to learn more about cocaine in order to prevent increased future problems.

This document is a consensus of the participants of a meeting entitled "Scientific Perspectives on Cocaine Abuse", which was held January 12-13, 1987 and sponsored by the American Society for Pharmacology and Experimental Therapeutics and the Committee on Problems of Drug Dependence.

The following people participated in the conference and the preparation of this paper:

Dr. Martin Adler
Dr. James Anthony
Dr. Robert Balster
Dr. Joseph Brady
Dr. Robert Byck
Ms. Kay Croker
Dr. William Dewey
Dr. Thomas Dunwiddie
Dr. Everett Ellinwood
Dr. Loretta Finnegan
Dr. Marian Fischman
Dr. Louis Harris
Dr. Leo Hollister
Dr. Jeffrey Isner
Dr. Jerome Jaffe
Dr. Peter Jatlow
Dr. Chris-Ellyn Johanson
Dr. Reese Jones
Mr. Gar Kaganowich
Dr. Sheppard Kellam
Dr. Keith Killam
Dr. Herbert Kleber
Dr. Mary Jeanne Kreek
Dr. Raymond Lorion
Dr. Donald Macdonald
Dr. Billy Martin
Dr. Charles R. Schuster
Dr. James Smith
Ms. Marilyn Waranch
Dr. Arnold Washton
Dr. Norman Weiner
Dr. James Woods

Senator DOMENICI. Thank you very much.

What I am going to do is have Senator Hollings take over now, and he will continue to hear testimony from the witnesses. But I want to make a couple of observations while you are all here and then thank my friend, Senator Hollings, for relieving me.

Let me first share an observation with reference to the mentally ill homeless. I am sure that the professionals that you are and the groups that you represent might wonder, well, how can we carve out a group of mentally ill because they are homeless and focus a program on them.

But I hope you also know that those of us who are strong advocates of trying to help that portion of the homeless population are aware that if you are seriously mentally ill you are seriously mentally ill, whether you are homeless or whether you are in a one-bedroom apartment as a 19 year old with a mother and father who do not know how to take care of you.

It is the same kind of problem. But it seemed to us that, if this country was going to spend a substantial amount of money on the homeless issue, we ought to recognize that a very large portion of that population suffers from serious mental illness.

And this was a rare opportunity, it seemed to this Senator and a number of others. Since we are not going to have enough money in this Nation to take care of all of the mentally ill with the family problems and the housing problems and brother and sister problems and everything else, that we ought to take the opportunity to spend some of this homeless money focusing on those problems.

I would merely comment that I think for the professionals this offers an equally rare opportunity, because we are going to be involved with substantial money. By the time we have finished, it will be a rather professional type program in each State, or they will not get the money.

I mean, they will have to meet the six objectives that have been enumerated here, which we developed with the coalition, and that are now included in both bills. And clearly, that means there will be a need for a major professional network to run the program in each of the communities that get the grants.

I urge that, wherever you are from, whatever your associations are, and whichever professional ingredient you complement, that you get involved in your respective States and help them prepare the right kind of program, with the right kind of professionals.

Incidentally, it does have another ingredient for training, because there was a concern that we would be doing this to the tune of maybe $100 million a year, plus $100 million for housing, and that the States would need some help in using this program as a training vehicle to develop the new consortium of professionals and quasi-professionals that are obviously needed. And so that is intended to do that.

My second point has a bit to do with what you learn rubbing shoulders with mothers, fathers, uncles, aunts, brothers, and sisters who have seriously mentally ill members of the family. And I would merely urge that, whatever your profession, from psychology to psychiatry and all of them, that you understand that, especially for young people from 15 to 24 or 25, this is truly a family disease.

I do not mean that every member of the family has the illness, but it is very, very difficult on the family to have somebody that is seriously mentally ill. And there must be a recognition by the profession that it is a family illness in the sense of everybody being affected.

And what we had for too long was almost an isolated treatment of the patient, without recognition in many instances of the family. And as a matter of fact, there is a substantial amount of evidence that the profession did not even want to include the family. Under the guise of privilege and other professional kinds of characteristics of the past, it was very difficult for the family to be part of this treatment.

I urge that wherever you can, consistent with your rules and your ethics, that you begin to consider to a maximum extent helping the family with the problem.

I can assure you that that is important, having now met hundreds of members of NAMI—and it is not exclusive, but the exclusivity is that you cannot belong unless a member of your family has a serious mental illness.

Go to one of their conventions, and you will see that they really suffer along with the ill member of the family, and they do not know what to do, either. I mean, it is not only the confused mentally ill person. The family is befuddled.

And frankly, I would hope that wherever you can as you proceed through this next couple of decades that you involve yourself in the techniques and new responses to that problem. I assure you it is growing, and groups who are worried about it are just growing by leaps and bounds in this country.

And they are your strength in terms of getting this Congress to respond. I mean, when this Congress begins to understand it is hundreds of thousands of people who are utterly befuddled by their 17 year old, who for the previous 16 years has been acting normal, when all of a sudden something just out of this world happens. When you have that across this land by the hundreds of thousands, they are the strength of what you have all asked us to do.

More support and continuity of support is needed, so that we get the very best coming into this field. And I assure you that that is the case. It is having an impact up here already, and when it reaches full bloom, when Congress understands their full strength, and I assure you they will—all will know that they are not nuisances and they are not in the way.

And if they are bugging you, you ought to let them bug you a little bit, because I assure you you are better off with them on your side than with them out there, putting together a massive campaign indicating that you are unresponsive. I will assure you of that.

My last observation has to do—perhaps I would ask two of the witnesses, if I might, is there a significant change in the attitude of the scientific community, in particular young scientists, about joining in research on serious mental illness that you can share with the committee?

Is it up? Is it down? Where is it vis-a-vis 4, 5, 6, 7 years ago?

Dr. FRAZIER. Senator, there is no question in my mind that there is a growing enthusiasm on the part of young scientists, especially neuroscientists and some behavioral scientists, to get in on the major illnesses, the major mental illnesses, the major affective disorders, the major schizophrenias, and to assist in research.

There is a very strong emphasis in molecular genetics, molecular biology, and the desire to do not just basic but also clinical research in this very important area.

Dr. DEWEY. I would agree with Dr. Frazier from the point of view that both scientists are very interested in both molecular biology and neuroscience at this time. There are increasing numbers in both of those areas, and those two disciplines are coming together to solve the diseases of the central nervous system.

Senator DOMENICI. Thank you very much. Thank you for bearing with me.

Senator Hollings.

Senator HOLLINGS [presiding]. I think we just heard the best witness. [Applause.]

Let the record show we have just heard from the best witness on mental health, our colleague Senator Domenici. And he speaks from his heart and he speaks with experience and he speaks with intellect on this problem.

I started—oh, I do not want to tell you the truth now—almost, let us see—from 1947 to 1987 would be, well, almost 40 years ago. And here we are.

The next witness we have this afternoon is Rodolfo Balli Sanchez, the chairman of the National Hispanic Family Against Drug Abuse, and we welcome you.

STATEMENT OF RODOLFO BALLI SANCHEZ, CHAIRMAN, NATIONAL HISPANIC FAMILY AGAINST DRUG ABUSE

Mr. SANCHEZ. I am originally from California, but I have been in Washington for 17 years, sir.

Senator Hollings, as the chairman of the National Hispanic Family Against Drug Abuse and as a member of the private sector, I am pleading for our Hispanic families' children, mothers, and for the future of America. I want to share with you two great concerns.

First, AIDS is having a devastating impact on our Hispanic communities. Our government, public health institutions, have convinced us that AIDS primarily strikes homosexuals. Our Hispanic community, particularly our young people, have believed this incorrect notion. The Hispanics who are intravenous drug users have not yet accepted or are aware that they are extremely vulnerable to the AIDS virus.

The views of these unfortunate members of our society is that, we are machos, we shoot drugs, only men do that. This ignorance about AIDS is having the devastating effect of a plague, a genocide.

Hispanics currently account for 14 percent of all AIDS cases and 23 percent of the pediatric cases. Yet, we Hispanics comprise only 7 percent of the population. Of all AIDS patients who are intravenous drug users, 30 percent are Hispanic.

Of all children with AIDS whose parents are intravenous drug users, 31 percent are Hispanic. In New York City alone, 60 percent of all Hispanic intravenous drug users test positive. Hispanics today are overrepresented among the victims of drug and alcohol abuse, including drug-related deaths and homicides.

For example, studies by the National Institute on Drug Abuse and others have found that Hispanics are nearly three times more likely to be in treatment for a problem related to drug abuse than whites.

Important portions of our community have been forced out of school and do not hear about AIDS prevention methods of the more organized nonminority communities.

We agree with Dr. Koop's statement that there is a disproportionately high number of AIDS cases among blacks and Hispanics. He linked the higher level of infection to higher rates of drug abuse in those groups than in the general public.

We have got to find more leadership in the black and Hispanic communities to focus attention on the disease, he said. We have got to talk about AIDS as it affects people in the south Bronx. But I also say, sir, we need to look at it in San Antonio, in New Mexico, Miami, and Los Angeles.

The Hispanic leadership responded by the creation of this new organization. We want to do more than our share, but we need your support, resources and commitment and that of public officials.

We recommend that an additional $20 million be provided for the coming fiscal year to enable the National Center for Disease Control, NIDA, and those departments within the PHS which are funding Hispanic prevention and education programs to target additional moneys to help us combat this dreaded disease in our communities. We are not getting the help we need.

Second, our recommendation for the Office of Substance Abuse Prevention and for NIAAA has been submitted to you in our written testimony. The Public Health Service, as well as the Department of Education, needs a directive from you to actively reach out to our communities and to work with us, not only in dialog but in appropriating moneys to correspond with our overrepresentation in the AIDS epidemic and substance abuse.

PREPARED STATEMENT

The data submitted in our written testimony clearly demonstrates the long neglect and lack of leadership to assist us to eradicate substance abuse in our communities, as well as to begin the war on AIDS in our Hispanic communities.

If we fail to act now on the subject of AIDS and Hispanic communities, it is we who must answer to the whole neighborhoods who will have been wiped out, leaving only the children.

Thank you.

[The statement follows:]

STATEMENT OF RODOLFO BALLI SANCHEZ

Mr. Chairman and members of the Subcommittee, thank you for this opportunity to present the views of our organization regarding federal funding priorities against drug and alcohol abuse, and in particular, the related threat of escalating AIDS infection among Hispanics and other minorities.

This is the first time that our organization, the National Hispanic Family Against Drug Abuse (NHFADA), has appeared before you. We are a new organization created late last year by Hispanic leaders in 22 states and Puerto Rico in direct response to the national crisis addressed by the Omnibus Anti-Drug Act of 1986 and related appropriations. At that time, there was no national vehicle which focused solely on mobilizing Hispanic communities across the country to participate fully in the programs and activities generated by the legislation. NHFADA was formed to serve as that vehicle, and a similar organization also has been created in Asian/Pacific communities.

In combatting substance abuse, our organization has three main objectives: (1) to raise national and local awareness of its destructive impact on family life, the future prospects of our youth, and the costly health, social, and economic consequences; (2) to foster private and public partnerships to develop effective solutions; and (3) to implement prevention, early intervention, education, and media programs specifically designed for differing Hispanic community contexts and for those Hispanic age and social groups most at risk and most underserved.

Guiding our efforts is a distinguished Board of Directors composed of members of the Congress, representatives of nine Hispanic national organizations, professional associations in mental health and substance abuse disciplines, public school systems, university research centers, churches, unions, business, and celebrities from the arts and entertainment.

LOOKING TOWARD THE FUTURE

For generations of Hispanics and other minorities, untreated dependency on alcohol and illicit drugs has been a problem far more severe than for the majority population. But the outlook for the future could be much worse for us because of two key factors:

1. The disproportionately high number of AIDS cases among Hispanics and blacks is linked to higher rates of drug abuse than in the general population. Hispanics account for 14% of all AIDS cases and 23% of the pediatric cases. Of all AIDS patients who are intravenous drug users, 30% are Hispanic; of all children

with AIDS whose parents are IV drug users, 31% are Hispanic. Also disturbing is the trend indicating a rise in the proportion of Hispanic and black women who have AIDS or who become infected by the virus through heterosexual contact. The Congressional Hispanic Caucus has given urgent priority to increased federal support for AIDS research and education, and NHFADA strongly endorses this effort. We also wish to commend the Surgeon General for his leadership in focusing national attention on the danger of the spread of the disease to our communities.

2. A greater proportion of Hispanics are in the age groups at highest risk for alcohol and drug abuse. The median age for Hispanics is 23.2 years vs. 31.1 years for whites. By the year 2000, the number of Hispanics under age 24 will rise to 11.5 million from the current estimated 8.9 million; by the year 2030, it will soar to 16.1 million or 80% higher than in 1987. Yet already:

-- Treatment data indicate that among clients, Hispanics tend to be the youngest (under age 25) at admission for heroin, cocaine, marijuana, PCP, and inhalants.

-- Lifetime and past use of cocaine is higher among Hispanics ages 12-17 than among either their white or black counterparts.

-- Drug abuse is strongly implicated in the alarmingly high rates of school dropout among young Hispanics, ranging from 50-77% in such cities as Boston, New York, Chicago, San Antonio, and Los Angeles.

-- Drug abuse among Hispanic youth is associated with more than 50% of delinquent acts which lead most often to incarceration, not to diversion for treatment and rehabilitation. Incarceration rates nationwide are dropping for white youth, but are rising sharply for Hispanic youth, and our youth are much more likely to be confined in public institutions than are whites who are far more likely to be routed to private facilities.

-- Drug and alcohol abuse by pregnant teenagers, who also usually drop out of school because of pregnancy, is a special area of educational and preventive concern because of the high birth rate among Hispanic teens and the risks posed to their health and the health of their infants. Of all Hispanic mothers giving birth, 19% are under age 20 vs. 12.1% for white non-Hispanic mothers.

-- While patterns of drug use among Hispanic youth involved differ from community to community, thus requiring a clear focus on the context of the problem in each locality, there are unique problems in states along the border with Mexico regarding the use of inhalants, marijuana, and alcohol among Hispanic youth. Inhalants especially are used by the youngest and the poorest.

Neither our communities nor our Nation can afford to lose any part of this generation or those to come to the hazards of substance abuse and the spread of AIDS. It is projected that we Hispanics will account for fully 25% of the Nation's growth in the next 20 years alone. The rapidly growing number of Hispanic teenagers and children represent a rich resource of talents and skills that will be needed to make America's future work force highly competitive at home and abroad, a point recently emphasized by the Secretary of Labor, William Brock, in commenting on the objectives for Project Youth 2000.

RECOMMENDATIONS

In view of the immediate urgent need in our communities and in view of the projections for the future, we believe that a different course is necessary, one that squarely faces the future. We ask that you consider the following:

1. A substantial increase in federal funds for AIDS education and prevention should be directed to programs and initiatives targeted to intravenous drug users and bisexual males in Hispanic and other minority communities and to women and young people in these communities. Substantial funding is also required for services and advocacy for those in our communities with AIDS, many of whom are virtually homeless, with low education and income, and unable to access much needed health and support services. Families and close relatives are not being helped to understand and appreciate the profound tragedy of this situation. A broad spectrum of Hispanic and other minority leadership -- including parent and youth groups, health and human service professionals, researchers, educators, clergy, civic, business, and community leaders, and media representatives -- should be mobilized and receive funding to implement these efforts.

2. Increased funding for the ADAMHA Institutes should be accompanied by a directive from the Congress requiring the agency to report, at least on an annual basis, as to how its current and projected use of the funds will address our present and long-range needs so as to make a critical difference for the future. The report should respond, among other items, to the following:

-- Treatment resources have been too scarce or too scattered to make a sizeable impact. Too often, the limited resources available have been directed primarily toward adults, leaving many of our communities with no readily accessible place where our adolescents can be treated and rehabilitated. Because of the low levels of health insurance coverage among Hispanics, many must rely for care on publicly supported programs.

-- Prevention is only now receiving priority attention, but adequate funding to realize its potential among our communities has yet to follow. For example, in reaching our burgeoning youth population, family-oriented prevention and early intervention hold great promise. Approximately 70% of mainland Hispanic youth ages 17 and younger live with both parents, and Hispanic culture places primal value on the family, both nuclear and extended, in shaping moral fiber and in developing responsibility to self and others.

-- No national coordinated research effort has been funded to generate a systematic, coherent body of data and scientific knowledge specific to Hispanic priorities in substance abuse. Nor has a similar coordinated effort been funded to to widely disseminate what limited, often fragmentary findings are at hand. In fact, the number of various Institute research grants relevant to minorities and their percentage in relation to all awards has been eroding, according to ADAMHA's own information.

-- The supply of Hispanic clinical and research personnel trained to serve our communities and to help make public policy more responsive to the actual conditions of our communities remains strikingly insufficient. Yet ADAMHA clinical training support for minority students has dropped from just above $4 million last year to an estimated $2.8 million this year, and support levels allocated for the Minority Biomedical Research Support Program and the Minority Access to Research Careers program have steadily declined since FY 1984.

In addition to requesting a report to Congress on how ADAMHA is wisely investing the funds entrusted to it in resolving such issues, we also wish to note that we support legislation introduced by Senator Inouye which would create the position of Associate Director for Special Populations in NIDA and in NIAAA, similar to the post established by Congress within NIMH. We believe the extension of this concept is important in keeping an integral focus on minority concerns throughout ADAMHA. We also believe the Congress should assure that sufficient resources are allocated within ADAMHA to support these positions adequately.

3. We recommend that an additional $20 million be provided for the coming fiscal year to enable:

-- The Office of Substance Abuse Prevention to expand its at-risk demonstration program to stimulate more community-based prevention efforts which are culturally sensitive to Hispanic and other minority communities and which can be replicated across the country. Emphasis also should be given by OSAP to the development of electronic and print media campaigns which tailor educational and preventive messages to specific audiences of at-risk youth and families in Hispanic and other minority communities. We have provided a detailed study to ADAMHA on major strategies for reaching and serving at-risk Hispanic youth and families through such demonstrations, and we would be pleased to share this document with the Subcommittee for your consideration.

-- NIDA and NIAAA to develop and implement an integrated, systematic research initiative to collect and publish data as well as produce special knowledge of Hispanic and other minority youth and family issues in epidemiology, treatment, prevention, culture-specific priorities, and questions concerning the characteristics and behaviors of specific groups of abusers at risk, including AIDS and minorities.

-- NIMH, NIDA, and NIAAA to increase the amounts allocated for training support to develop minority clinicians to provide services to the growing numbers in need as well as to develop minority investigators to conduct research and to help shape the directions of ADM research for the future.

Mr. Chairman and members of the Subcommittee, thank you again for this opportunity to share our views with you. Our organization looks forward to a continued good relationship with you. We would be pleased to answer requests you may have for additional information available to us on the matters discussed today.

Senator HOLLINGS. Thank you very much.

The Spanish community is known for its family responsibility, and I take it the incidence of drug use and drug abuse is really economic, would you not say?

Mr. SANCHEZ. I would say that it has a portion of that. But I would also say that such—take for instance, the Say No Program does not have an impact in our communities. If you see television, you hardly ever seen an Hispanic celebrity or Hispanic athlete informing our communities.

The materials that have been produced are translated, and most of the people that are affected in substance abuse are really dropouts. They do not read. We need to find new effective ways, not the traditional modes. We need to use electronic media.

We need to use what we call in Spanish teatro, which is theater. We need to use puppets, things that people can see and visualize. We have not been faced with such a disease like this.

First of all, homosexuality is refused in our community, is ignored. And thousands and thousands of people are now dying, and it is affecting—like Senator Domenici said, you know, the families do not know what to do. This will be a tremendous cost to our Nation in mental illness.

And most of these people do not have health insurance. So we are faced with a tremendous problem, sir.

Senator HOLLINGS. All right. This is an Appropriations Committee. How much money are you asking for?

Mr. SANCHEZ. If I really said what I feel, and I am going to say it, there is enough existing money. The fact is that it is not being diverted to our communities. The tremendous millions of dollars—as you saw all of these people speaking here about research, did they say anything about producing Hispanic research scientists?

And the prevention money that is presently being allocated to the National Center for Disease Control, just appropriate so much money. And do you know how much money they said for Hispanics to educate our children? $100,000.

But if Hispanics come up and speak, then they cut off their funds. But since I am a member of the private sector, they cannot hurt.

Senator HOLLINGS. I think, with respect to the translation, you are right. But, generally speaking, you would not provide for German children, of German descent. That would be my crowd.

But you do not have educational programs except for the language differential, and I understand that, and we have bilingual programs. I understand what you are saying. But I think you need a general education. I do not think it is just applicable to Hispanics. I think it is applicable to all.

You have got some good ideas on how to approach those Hispanic groups and I think we ought to use them.

Mr. SANCHEZ. Well, all I can say, sir, is that if our Nation does not face this problem—I used to be in the nonprofit, I used to be the national director of a huge organization and I left after many years. Some 20 years ago I was saying the same thing: We have got to divert some of that existing money into our community.

And the dropout rate, we need to focus on that. We need to educate our people. We Hispanics have to take the leadership and educate our own people. But we also need the resources of the Federal Government.

The block grant moneys that are going to the States for substance abuse are not reaching our Hispanic communities, because our Hispanic communities do not have access to the State legislation and do not have access to those in power. We have not developed the kind of people, or they say we have not, who can produce a proposal that competes.

We are in a kind of catch 22. So in 20 years I will probably not be here, but there will be another Hispanic saying the same problems, stating the same problem, and more costly to this Nation.

What about the work force? Secretary Brock and Senator Bowen said that minorities youth will be the major work force of this country in the year 2000, 2015.

Senator HOLLINGS. Very good, sir. We appreciate your appearance.

Mr. SANCHEZ. Thank you.

Senator HOLLINGS. We are under a time constraint. I would like to spend more time with each of these witnesses, but we have got about twelve more here.

Is Mr. Boswell, executive director of the Cottage Program International, here?

STATEMENT OF BERNELL N. BOSWELL, EXECUTIVE DIRECTOR, COTTAGE PROGRAM INTERNATIONAL, INC.

Mr. BOSWELL. Thank you, Senator Hollings.

I am Bernell Boswell, executive director of the Cottage Program in Salt Lake City, UT. The Cottage Program is a community based, family focused alcohol and drug abuse prevention program which has been replicated in 1985 communities across the United States and adopted by several hundred others, both here and abroad.

I would like to express my appreciation for the opportunity to address the subcommittee on some areas which are of pressing concern to socially aware Americans everywhere: the disease of alcoholism and its connection to the plight of the homeless.

Their plight is not news to volunteers and professionals who for years have tried to help them survive the night, nor to the compassionate business community which has so often helped make that task possible.

Historically, the alcoholism community has done a good deal more for our homeless than provide them with a needed meal. Treatment and the fellowship of the recovering community has for many provided a secure bridge back to a productive life.

I urge you not only to designate new funds for alcoholism treatment to help the homeless alcoholic, but to increase support to the National Institute on Alcohol Abuse and Alcoholism in its scientific efforts to find the actual reasons for the problems and the most efficacious way to help our homeless return to the dignity of self-support.

I would like to encourage you to support approaches which not only treat the immediate problem, but set in motion a mechanism and the resources to prevent its perpetual reoccurrence.

In addressing the problem of the homeless, we can learn a great deal from the alcoholism field. When we started, the best we could look forward to was a continuous cycle of treatment for each new generation of alcoholics. Now, in large part because of the research efforts of NIAAA and the ability to apply these findings by many effective prevention and treatment programs, we can realistically envision a day when society is all but free of alcohol abuse and alcoholism.

To achieve that, we must capture the interest, understanding, and commitment of all Americans.

PREPARED STATEMENT

Finally, I would like the subcommittee to support the professional judgment 1988 funding level for NIAAA, NIDA, and the ADAMHA block grants.

Thank you. I just wanted to try to beat that light.

[The statement follows:]

STATEMENT OF BERNELL N. BOSWELL

Mr. Chairman, and members of the Subcommittee, I am Bernell Boswell, Executive Director and Founder of The Cottage Program International Inc., Salt Lake City, Utah.

The Cottage Program International, Inc. is a private, non-profit, community based, family focussed prevention program. For the past 15 years, The Cottage Program has actively pursued the challenging task of effectively treating and ultimately preventing alcoholism and alcohol abuse. We provide a comprehensive array of prevention, intervention and outpatient treatment services.

Our ambitious goals go well beyond the compassionate, efficacious treatment of alcoholics and their families. We are committed to the realization of a society that is incompatible with and inhospitable to alcohol abuse.

Since I founded The Cottage Program 15 years ago, I have witnessed a social and scientific revolution in the alcoholism field. That revolution is still in progress. The technologies needed to: treat alcoholism with scientific confidence and competence; correctly identify those who are at high-risk of developing alcoholism; and, effectively preventing alcoholism and alcohol abuse, are within our grasp. But they are not securely in hand. We need to renew and expand our efforts in those areas of research and application which have shown so much promise.

At the same time, we cannot relax our efforts to create the social motivation, private resources and professional expertise so needed to effectively apply those technologies.

It is the application of new technologies, making them readily available to every American, and the eventual elimination of alcoholism and alcohol abuse which has been the driving force of my professional and personal life.

The opportunity to address this Subcommittee on some areas of critical interest to the alcoholism field is genuinely appreciated. I am concerned with NIAAA's research and training programs, as well as its present capacity to effectively address the alcoholic problems of the homeless. Specifically, I am concerned that: NIAAA is not able to fund more of the high quality research applications it receives each year; research training, which is the only method we have to assure good researchers in the future, is being neglected; physicians and other health care workers are not being adequately trained to diagnose and treat alcoholism and alcohol-related problems; and I am concerned about the plight of the homeless alcoholics. I am also concerned because NIAAA is understaffed in relation to the challenges and opportunities it faces. As a person who has been in the field for many years, runs one of the premiere prevention programs in the Country, and has served on a number of distinguished panels regarding alcohol abuse and its prevention, I am familiar with the Institute's budget, with its high-quality programs and with the hard choices that have to be made in allocating scarce resources. I urge this Subcommittee to consider a significant increase in funding for NIAAA.

This is an exciting time for research on alcohol abuse and alcoholism. The opportunities for productive research have never been greater. A good deal has been accomplished over the past few years and many new areas of research have been opened up. One of the most significant achievements has been the confirmation that heredity is a major contributor to alcoholism in a large proportion of cases. Research is now providing insight into the physiological and molecular basis of this genetic predisposition. I firmly believe that expanded research in this area over the next few years can lead to some remarkable results -- methods of early identification of persons at risk for developing alcohol problems, improved prevention and treatment.

Important finding are being made across a range of topics and the need for a wide diversity of research efforts contributes to the need for a higher funding level. For example, research has found that alcohol effects every major component of the immune system. There is an immediate need to learn more about the relationship of alcohol abuse to infectious disease. There is also a need for expanded research on the efficacy of treatment and prevention methods.

I concur with the professional judgement of the Research Society on Alcoholism, the APA and other groups who are recommending a 1988 funding level for NIAAA of $111.4 million with 234 FTEs. I also support the professional judgement budget proposed for the other ADAMHA Institutes which would provide $330.0 million for NIMH research, $183.0 million for NIDA research, and $32.0 million for the research training programs of the three Institutes. In addition, I affirm funding the ADM Block grant program at $650.0 million, supplemental treatment grants at $195.0 million, and service demonstrations at $24.0 million.

The level of funding proposed would allow NIAAA to meet funding shortfalls that exist in the Administration's request and would provide for a moderate level of growth. The recommended funding includes an increase over the request level of $20.6 million for research, $1.7 million for research training, $1.0 million for clinical training and $2.8 million for management and support of the extramural programs, $.5 million for building a facility maintenance, and most importantly $3.0 million for a new homeless initiation.

The problem of alcoholism among the homeless is of special concern to me. NIAAA has provided leadership for the homeless population with alcohol problems since the formulation of its 1972 public inebriate program, and more recent support for research to improve our understanding and service delivery capabilities focusing on this population. NIAAA needs to continue its efforts in developing ways to address alcohol problems among the homeless population. Research supported by NIAAA suggests that 20 percent to 45 percent of homeless Americans have alcohol problems.

A homeless initiative of $3 million would provide support for up to 9 research and evaluation demonstration projects on the homeless with alcohol problems. The purpose of these research and evaluation demonstration projects is to develop, document, and evaluate innovative alcohol treatment and service delivery programs for the homeless with alcohol problems. These research demonstration projects would provide new information on epidemiology, clinical and treatment aspects, and service delivery systems and costs. Three of the nine projects would be targeted specifically for the homeless mentally ill alcoholic and would be developed in conjunction with NIMH.

We cannot afford to further penalize the homeless simply because of their present condition. Making alcoholism treatment services available to all those in need should be our goal. The benefit which the homeless derive from treatment can be critical and lasting. Treatment for the homeless not only directly addresses the disease of alcoholism, it can also provide a needed bridge back to productive living.

Senator HOLLINGS. You did. I congratulate you for it.

Let me just say, you headed up the Cottage Program. Do you know any responsible group in this country that has any kind of research finding with respect to the cause of alcoholism?

Mr. BOSWELL. Well, I think the people who are going to follow me have a great deal of information regarding research efforts addressing the cause. But I think the cause, actual cause, still remains unknown.

However, there is—we have got a great deal of research information now which clearly indicates that the genetic predisposition for alcoholism is really quite clear.

Senator HOLLINGS. I agree with you. I think the genetic connection is there. I am beginning to be a nut on the subject of the chemical deficiencies of some kind. Maybe that is tied in with the genetic makeup. I do not know. I have been watching it for years.

Mr. BOSWELL. Well, certainly my colleagues who are following me, I think each of them have their own expertise in research.

Senator HOLLINGS. Well, anyone who has got a cause—you know, I grew up helping sponsor the Alcoholics Anonymous Program and the alcoholic treatment centers and everything else, all under the premise that they would look—they would say, look, we know we cannot cure it, but we can arrest it.

And then you said research into the cause, and then you are getting me a cure if you can find the cause.

Mr. BOSWELL. I think so.

Senator HOLLINGS. I would like to see that day come. That would be as good as finding a cure for cancer.

Mr. BOSWELL. Yes; especially when in this country we are looking at over 18 million alcoholic and problem drinkers.

Senator HOLLINGS. Very good. Thank you very much, sir.

Mr. BOSWELL. Thank you.

STATEMENT OF IRVIN L. MUSZYNSKI, JR., NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS

Senator HOLLINGS. Our next witness is Hon. Irvin L. Muszynski of the National Association of Addiction Treatment Providers. Maybe you have got me a cure.

Mr. MUSZYNSKI. Well, Senator, I do not know about that, but I do have something to say about something that impacts on cure and arrest of the disease.

As you noted, my name is Irvin Muszynski. I currently serve in the capacity of general counsel for the National Association of Addiction Treatment Providers, which is a national association of over 600 private sector treatment programs, both hospital-based and free-standing programs, offering in-patient, residential, and outpatient regimens of care.

We appreciate the opportunity to speak before you today regarding our special concerns about fiscal year 1988 appropriations for the programs of the Alcohol, Drug Abuse, and Mental Health Administration. Our detailed comments are before you in the written statement that we have submitted to you.

And my oral testimony I really wish to draw two matters of special concern of ours respecting fiscal 1988 appropriations to your concern, the first being what we feel is a strong and continuing need for treatment-related research, that is patient placement research, matching patients by type and need with appropriate types of care in the appropriate setting of care, and second, research respecting both the effectiveness and capacity of the existing alcoholism and drug dependency service delivery system and appropriate methods of financing for this care.

With regard to the first point of concern of ours, the treatment-related research, we really want to just point out, as you well know, both NIDA and NIAAA, these institutes have been instrumental over the last 10 to 20 years in the furthering of our knowledge about both the causes and treatment and prevention regarding alcoholism and drug dependency.

They played a vital role for the chemical dependency field and many of the inroads we have made both in the prevention and treatment research are due to their research efforts. Needless to say, we feel strongly that strong support for this research needs to be continued.

No doubt, with history as a guide, the bulk or the lion's share of this research money will continue to go into biomedical research to help us all better understand the very nature of alcoholism and drug dependency conditions. We strongly support the continuation of efforts regarding biomedical research under these conditions.

In addition to this effort, however, we also think there needs to be a continued and special emphasis to the generation of research which directs itself to the question of what type of treatment and what setting of care is appropriate for which type of alcoholic or drug dependent patients.

What are appropriate lengths of stay and treatment regimens? We need to see the furtherance and the development of common definitions of recovery, definitions regarding success and failure rates, and so on.

The answers to these questions are ones that the treatment field desperately needs, and I think will foster the continuing development of public policy on the issue of the treatment of alcoholism and drug dependency conditions.

PREPARED STATEMENT

The Office of Technology Assessment in its 1983 report, "The Effectiveness and Costs of Alcoholism Treatment," suggested that we continue this emphasis. The field has responded, and we respectfully acknowledge your strong support for this in the past and ask that you provide increased funding in the future for these treatment-related efforts, as suggested in our written statement.

Thank you, Senator.

[The statement follows:]

STATEMENT OF IRVIN L. MUSZYNSKI, JR.

The National Association of Addiction Treatment Providers (NAATP) appreciates this opportunity to address the Labor, Health & Human Services and Education Appropriations Subcommittee on FY 1988 appropriations for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) and, particularly, its National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA). NAATP is the only national health care organization devoted solely to issues in alcoholism and drug dependency treatment. NAATP represents more than 600 private-sector treatment providers throughout the country, both non-profit and for-profit, offering inpatient, residential and outpatient regimens in both hospital-based and free-standing settings.

For more than a decade, NIAAA and NIDA have comprised the focal point within the federal government for advancement of treatment, prevention and research regarding alcoholism and drug dependency. The Institutes have played a vital role for the chemical dependency field, as well as for society as a whole. Many of the seminal inroads we have made in dealing with alcoholism and drug dependency have been the direct result of findings made possible through research generated and funded by NIAAA and NIDA.

Alcoholism and drug dependency are estimated by ADAMHA to be the third leading cause of death and disability in the United States, trailing only heart disease and cancer in their magnitude. For several years, now, the Institutes have also estimated that 85% of citizens in need of treatment for their dependency never seek or receive that treatment. Untreated alcoholism and drug dependency--their ravaging effects devastating nearly every organ and system in the body--are indeed today's "American Tragedy." Perhaps the greatest tragedy is that through modern techniques, constantly being researched and refined through efforts supported by NIAAA and NIDA, these disorders are eminently responsive to appropriate treatment. Yet the stigma which surrounds alcoholism and drug dependency prevents many in need of help from seeking that help, and many family members and friends from encouraging it.

For many years, alcoholism and drug dependency treatment has been offered mainly on an inpatient basis in a hospital setting. One of the reasons this particular modality has prevailed is that most private insurance coverage for addiction treatment has covered only hospital-based settings. Since the inception of the Alcohol, Drug Abuse and Mental Health Block Grant, there has been a dramatic shift in the majority funding for addiction treatment from public sources to private ones. Additionally, and to some degree in response to this phenomenon, the treatment field has developed what it calls the "levels of care" concept. This concept, which attempts to match the severity of each individual patient's disability with an appropriate intensity of service or level of care, must continue to be recognized, researched and refined. NIAAA and NIDA are currently funding this kind of research and, indeed, NAATP believes that such research should remain a priority of both Institutes.

LEVELS OF CARE IN ALCOHOLISM AND DRUG DEPENDENCY TREATMENT

Just as there are several types of cancer and heart disease, there are, as well, many types or degrees of alcoholism and drug dependency. The variables, in diagnosis, can relate to gender, age, alcohol and drug history, family impact and history, employment (history and type), previous treatment experience, overall physical condition, motivation to recover, etc. To deal with the different levels of alcoholism and drug dependency, the treatment field has developed three basic modalities, or levels, of care: inpatient, residential and outpatient.

The inpatient level of care is usually best for the severely sick, long-dependent patient, who generally presents for treatment with concomitant medical and psychiatric complications, and who needs absolute separation from the trappings of everyday life. The residential level of care is an intermediate one, less medically-intensive and, thus, appropriate for patients not experiencing psychiatric or advanced medical problems, but who still need the benefit of a therapeutic milieu. Outpatient programming is considered appropriate when the patient is in the earliest stages of the disease and whose dysfunction has not become entirely unmanageable.

HOW TREATMENT COST IMPACTS TREATMENT CHOICE

One of the greatest issues confronting the public today is the problem of ever-increasing health care costs. The era of health care cost containment and managed care is upon us; we in the alcoholism and drug dependency treatment field welcome it because we firmly believe that appropriate treatment for dependency stands as its own cost containing and care management measure. This is, in fact, undeniable in comparison to the never-ending costs of treating the myriad consequences of untreated alcoholism and drug dependency.

The March, 1983 report of the Office of Technology Assessment, The Effectiveness and Costs of Alcoholism Treatment (Health Technology Case Study #22), eloquently concluded that "...it costs more not to treat alcoholism than to treat it." However, this landmark report underscored the fact that the notable lack of methodologically sound treatment assessment research in alcoholism and drug dependency leaves many important questions unanswered. The basic question, in the absence of reliable research data, still remains: What type of treatment is appropriate for which type of alcoholic or drug dependent patient?

The answer to this question must be more than merely a function of cost. With the aforementioned stigma accorded alcoholism and drug dependency and its victims, we must guard against implementation of a public policy which simply states that alcoholic and drug dependent patients deserve only the least intensive--thus the least costly--level of care. Certainly, this was the philosophy which prevailed thirty to forty years ago, when alcoholics and addicts were deemed incurable and relegated to asylums offering little more than custodial care.

The alcoholism and drug dependency treatment field, itself, has responded to the recognition of different severities of dependency with the "levels of care" concept. The field has been continually refining its diagnostic techniques, in order to determine the most appropriate levels of care for alcoholic and drug dependent patients. While insurance coverage--albeit to varying degrees--is available largely to inpatient, hospital-based programs, it is scanty, indeed, for residential and outpatient treatment. This is, certainly, a contradiction in terms with regard to cost containment.

As a result, the Office of Technology Assessment called for the creation of a "patient placement system," to match alcoholic and drug dependent patients to the appropriate levels of care based on the severity of their disease upon diagnosis and admission. NAATP has wholeheartedly supported this idea since it was advanced by OTA, and two years ago NIAAA began to aggressively move forward on the OTA's suggestion. NAATP believes that the importance of this research should continue to be underscored by this Committee in FY 1988 as it has in the past, including cooperative efforts between NIAAA and NIDA on patient placement research. NIAAA and NIDA need to continue to generate high quality and appropriate grant and contract proposals on patient placement and to be able to fund the best research proposals.

CONTINUED EMPHASIS NEEDED ON TREATMENT-RELATED RESEARCH

Many historic and welcome advances have been made in the alcoholism and drug dependency treatment field as a direct result of ADAMHA-funded research. There is little doubt that the lion's share of FY 1988 appropriations for NIAAA and NIDA will go toward biomedical research, to help us all better understand the effects of alcohol and other drugs on the body, the very etiology of addiction, the interaction of alcohol with other drugs, etc. NAATP is highly supportive of the need for biomedical research, but also believes that greater attention should be paid to treatment assessment and financing research. While many NAATP member programs regularly review and assess their treatment, including its costs and its outcome, it is crucially important that respected, non-vested entities such as federal research Institutes become more involved in this vital area of research.

NIAAA has displayed welcome leadership on the issue of patient placement research and we are grateful to this Committee for its enduring encouragement of these efforts. The Institute has inaugurated exquisitely important, long-term studies of patients and settings, in order to determine systems by which to assign levels of care according to illness severity. The effort called for in Section 1923 of the Anti-Drug Abuse Act of 1986 (PL 99-570) has been an excellent step forward for patient placement research; should this Section of the Act be reauthorized, NAATP supports appropriations similar to those provided for FY 1987.

NAATP believes that NIDA should continue its patient placement and other treatment-related research, as well. NAATP lauds NIDA's research on various components of the treatment process and its categorization of varying patient needs. We urge the Committee to continue its support for NIDA's important work in the such areas as screening procedures for treatment candidates, severity profiles pertinent to diagnosis, treatment efficacy and effectiveness studies, treatment delivery, monitoring and outcome evaluation and aftercare and post-treatment follow-up.

For too long, these Institutes and, in fact, these related fields of endeavor have observed strict political and clinical separation. Today, all alcoholism treatment programs are truly alcoholism and drug dependency treatment programs. The vast majority of today's dependency patients present with addiction to other drugs in addition to alcohol. NAATP commends the Alcoholism and Drug Abuse Institutes for their cooperative and collaborative efforts to date. It is fitting that the national research effort should reflect current clinical practice and we trust that will continue.

Such an effort, generated by ADAMHA, could answer so many of the questions raised by the OTA report, by the Health Care Financing Administration, by private insurers, reviewers and employers and even by the alcoholism and drug dependency treatment field itself. The information we seek relates to appropriate lengths-of-stay and treatment regimens, development of common definitions of recovery, success/failure rates--and why. Without the answers, how can we determine an appropriate public policy on the treatment of these disorders?

TREATMENT FINANCING/COVERAGE POLICY RESEARCH & EVALUATION

NAATP is grateful to this Committee for its strong support in the past for the treatment financing and coverage policy research and evaluation effort at ADAMHA. The work of this new Office, budgeted under the ADAMHA program management line, has already borne fruit with creation of a new and encouraging DRG configuration for Medicare financing of alcoholism and drug dependency treatment. The issue of public and private coverage policy goes hand-in-hand with the notion of appropriate patient placement: the former dealing with the economic side and the latter dealing with the clinical side of furnishing the most effective and efficient care to chemical dependency patients.

We respectfully ask the Committee to support this effort at a greater level. Between 1981 and 1987, hundreds of millions of Federal dollars have been distributed to the States to support alcoholism and drug dependency services. Yet, virtually no crosscutting service system assessments have been undertaken by ADAMHA. A well-designed evaluation system is sorely needed to determine profiles of those who seek treatment (as well as those who do not), to find out how provider selections are made and to characterize the types of care and the types of providers available to those in need. Additionally, we need to know the costs of care and the alternative settings available, the extent of interface among public and private programs and how well the system is functioning to meet the national treatment need.

The ADAMHA Office of Financing and Coverage Policy has a unique potential to supply sorely needed answers to pressing national policy questions. The Office can assess alternative approaches to the financing and coverage of services in order to encourage efficient and effective treatment. Augmented evaluation ofthe effectiveness of demand reduction activities and treatment delivery initiatives can identify gaps in the system as well as focusing on referral patterns and the differences among sites of service.

The Office needs additional support for research to analyze and assess the effects of public and private health care reimbursement policies on the adequacy and availability of alcoholism and drug dependency treatment services. This analysis is extremely important in the ongoing consideration of how to structure reimbursement for these services as well as for those pertinent to mental illness, under capitated or prospective payment systems.

CONCLUSIONS AND RECOMMENDATIONS

The National Association of Addiction Treatment Providers respectfully recommends the following to the Committee:

1. That NIAAA and NIDA continue their important emphasis and coordinated efforts on patient placement research, with assistance to the field in creation of quality grant and contract proposals on such research.

2. That the Committee appropriate $89.5 million for NIAAA for FY 1988, which would permit:

--Award of approximately 130 new and competing research project grants at Council-approved levels, providing needed funding for priority areas, including biomedical as well as treatment-related research;

--Full funding and expansion of existing Alcohol Research Centers;

--Expansion of the Intramural Research Program, with limited increases in personnel, equipment and facility renovations to take advantage of the newly-establish clinical research program located on the NIH campus;

--Expansion of the Research Scientist Development Awards with special emphasis on clinical researchers.

3. That the Committee appropriate $183 million for NIDA for FY 1988, which would:

--Increase the number of new and competing research grants to 220;

--Provide a true "current services" budget for FY 1988, maintaining the Council-approved level of new and competing projects for FY 1987;

--Allow continued research to match drug-addicted patients to appropriate levels of treatment and rehabilitation; and

--Permit continued research on the links between IV drug use and the spread of AIDS.

4. That the Committee appropriate $13.925 million for ADAMHA

program management, of which $6 million be specifically dedicated to operations and staffing for the continuation of the Office of Financing and Coverage Policy, and its essential research of service systems and payment issues relative to alcoholism, drug dependency and mental illness.

5. That the Committee appropriate $650 million for funding of the FY 1987 Alcohol, Drug Abuse and Mental Health Services Block Grant and State Supplemental Alcohol and Drug Treatment Grants and that adequate funds be made available for appropriate evaluation of the activities funded.

NAATP wishes to express its support for ADAMHA's many contributions to the alcoholism and drug dependency treatment field, both present and potential. There is a need for continued emphasis on treatment assessment and related research which, in the current climate, surely approaches the importance of biomedical research.

This concludes the formal statement of the National Association of Addiction Treatment Providers. We appreciate the opportunity to express our views, and respectfully request that this testimony appear in the official record of this hearing.

Thank you.

Senator HOLLINGS. Well, we thank you.

I am sure Senator Chiles and the subcommittee will want to try to meet those spending levels. It is going to be difficult, but we are going to do our best this year.

Mr. MUSZYNSKI. We thank you.

Senator HOLLINGS. The Senate has just passed about the best budget you could get last night late, after working since January. And so you can see, they have been working hard on it.

And this is a field that, the more we apply the better results we get. And so I do not look on it economically as any waste whatever.

Mr. MUSZYNSKI. Thank you, Senator.

Senator HOLLINGS. Thank you very much.

Ms. Christine Lubinski.

STATEMENT OF CHRISTINE LUBINSKI, WASHINGTON REPRESENTATIVE, NATIONAL COUNCIL ON ALCOHOLISM, INC.

Ms. LUBINSKI. Good afternoon, Senator. My name is Christine Lubinski and I am the Washington representative for the National Council on Alcoholism, the oldest and largest field group in the field of alcoholism. And we see ourselves as advocates for alcoholics, other drug addicts, and their families.

I would like to briefly outline NCA's recommendations regarding the appropriations for Federal alcohol and other drug programs funded under the Public Health Service Act and spend a brief period sharing information about NCA's study regarding the women's set-aside of the ADMS block grant.

NCA urges the subcommittee to approve NIAAA, NIDA, ADMS block grant and supplemental alcoholism and drug abuse treatment grants appropriations substantially in excess of the administration's request, which we feel represents a cynical attempt to cut off short the effort imposed by the Anti-Drug Abuse Act of 1986.

We urge subcommittee members to appropriate $89.5 million for NIAAA research budget for fiscal year 1988. We have a great deal more to learn in the area of alcoholism research and alcohol in general, and certainly today's headlines regarding the high risk of alcohol use by women for breast cancer indicates just another area that we are just beginning to discover.

We also urge $4.4 million for research training, at least $1 million for clinical training, and $12.8 million for direct ops.

In the area of new initiatives, we strongly urge you to look at the predicament of homeless alcoholics and other drug addicts, who have been notably absent as a major focus of the homeless initiative going through the Congress. We ask for a demonstration program for NIAAA to address the special needs of alcoholic and drug dependent homeless individuals, to provide desperately needed services for these difficult to reach and treat populations.

We join a host of other organizations in a request for an appropriations level of $611 million for the ADMS block grant and $195 million for the supplemental alcoholism and drug abuse treatment grants.

We also ask that the grant program of the Office for Substance Abuse Prevention be expanded to include populations other than high risk youth. All prevention initiatives were taken from NIAAA and NIDA and put into the new OSAP office, and it is important that the prevention needs of all populations should be addressed, that is, kids that are not determined to be high risk by statutory definition, as well as women and minorities.

We strongly support continuation of the 5-percent setaside of the block grant for services for women with alcohol and other drug problems. NCA received funding from the Ford Foundation to study the implementation of the women's set-aside. We received responses from 45 States and three jurisdictions to our survey and visited eight States.

Our study has shown that the set-aside has been successful in bringing to life a broad range of new prevention and treatment programs for women. Most States made a genuine attempt to respond to the spirit of the legislation, and continuation of the set-aside is critical for the future of these programs.

Women still continue to be significantly unrepresented in treatment programs for both alcoholism and other drug dependency, and it is important that programs which meet their needs continue to be expanded and developed.

PREPARED STATEMENT

Thank you for giving us the opportunity to testify. I would be happy to answer any questions you might have.

[The statement follows:]

STATEMENT OF CHRISTINE LUBINSKI

The National Council on Alcoholism is the leading voluntary health organization working nationwide to prevent and reduce alcoholism and other alcohol and drug related problems.

The federal programs under consideration in these hearings represent the heart of the federal effort to reduce and prevent alcoholism and other drug problems in American society. NIAAA and NIDA represent the research backbone of the federal commitment to reduce the toll of alcohol and other drug problems. The Alcohol, Drug Abuse and Mental Health Services block grant serves as the primary source of prevention and treatment funding to states, funds which are translated into public alcoholism and other drug prevention and treatment services in communities across the nation. The Office for Substance Abuse Prevention and the Emergency Supplemental Treatment Grants, both authorized under last year's Anti-Drug Abuse Act of 1986 represent the most recent developments in a comprehensive federal plan to address these major health and social problems.

The Anti-Drug Abuse Act of 1986 was conceived as the beginning of a concerted and comprehensive national effort to reduce alcohol and other drug problems in America. Unfortunately, the President's budget request for fiscal year 1988 reflects a cynical, one time response to health and social problems which are pervasive and endemic. Moreover, without continued funding, many of the research, prevention and treatment efforts funded under last year's major initiative will contribute little in the way of a lasting impact on the nation's alcohol and drug problems. We hope that this Committee will not contribute to this short-sighted view, and will instead appropriate adequate funding for all of the alcohol and other drug programs authorized under the Public Health Service Act for fiscal year 1988.

NCA would like to focus its testimony on issues pertinent to appropriations for NIAAA and the ADMS block grant. Before doing so, NCA lends its support to the appropriations recommendations of some two dozen organizations in the alcohol, drug abuse, and mental health fields for NIDA and the Office of Substance Abuse Prevention. Those recommendations include an appropriation level of $183 million for NIDA research and a fiscal year 1988 funding level for OSAP of $65 million, which includes $38 million for demonstration projects. The grants for high-risk youth should be maintained at the $20 million level with an additional $18 million provided for demonstration grants for other populations including youth who do not fit the high-risk profile, as well as women and minorities. Since all of the federal alcohol and drug prevention activities have been consolidated at the OSAP level, it is important that OSAP's focus be broadened if the prevention needs of all populations are to be addressed.

National Institute on Alcohol Abuse and Alcoholism

Historically, the NIAAA research budget has paled in comparison to federal research efforts for other illnesses, despite alcohol's very substantial contribution to mortality and morbidity and an annual economic toll on the nation of well over $116 billion. Recent increases in the NIAAA budget must be continued if the recently declared "war on drugs" is to begin to effectively address the nation's leading drug problem -- alcohol.

The National Council on Alcoholism encourages the Subcommittee Members to appropriate $89.5 million for the NIAAA's research budget. This funding level would allow for the award of approximately 130 new and competing research grants at Council-approved levels, including funding for the evaluation of various prevention and treatment approaches. In addition, NCA supports an appropriation of $4.4 million for research training, at least $1 million for clinical training and $12.8 million for direct operations.

In the area of new Institute initiatives, NCA urges the Subcommittee to consider an appropriation of at least $15 million for the development and evaluation of demonstration projects for homeless alcoholics and other drug dependent persons. In our view, the prevalence of alcoholism in the homeless population has been consistently overlooked in previous initiatives to provide services to this population. The NIAAA has provided leadership for the homeless population with alcohol problems since formulation of its 1972 Public Inebriate project, and more recent support for research to improve our understanding and service delivery capabilities focusing on this population. The purpose of these demonstration projects is to develop, document and evaluate innovative alcohol and drug treatment and service delivery programs for the homeless with alcohol and other drug problems. Several of these projects should be targeted specifically for the homeless mentally ill alcoholic and drug addict, and could be developed in conjunction with the National Institute of Mental Health. A modest program to address the special needs of alcoholic and drug dependent homeless individuals will provide desperately needed services with critical research and evaluation components for this difficult to reach and treat population.

Alcohol, Drug Abuse, and Mental Health Services Block Grant

The National Council on Alcoholism joins other leading organizations in the alcohol, drug abuse and mental health fields in a request for an appropriations level of $611 million for the ADMS block grant and $195 million for the Supplemental Alcoholism and Drug Abuse Treatment Grants. The national focus on the nation's drug crisis last year brought into sharp relief the inadequacy of the public treatment system to serve all of those individuals seeking treatment for alcoholism and other drug dependencies. Emergency funds were appropriated in last year's omnibus anti-drug initiative to aid in reducing waiting lists for alcoholism and drug abuse treatment in many areas of the nation. This money served to augment a grossly underfunded federal treatment program and must be continued.

The women's set-aside of the ADMS block grant was authorized three years ago as a vehicle to expand public prevention and treatment services available to women with alcoholism and other drug dependencies. In May 1986, the National Council on Alcoholism received funding from the Ford Foundation to monitor the implementation of the women's set-aside of the ADMS block grant. The NCA report examines how states responded to this federal initiative in its first full year of operation. As a result of the federal set-aside mandate, the last three years have seen a dramatic increase in services to women in most states.

The set-aside has brought to life a variety of alcohol and other drug prevention, education and treatment programs designed to address the needs of women. Among the 45 states and 3 jurisdictions which responded to our call for information, none failed to make a genuine attempt to respond to the spirit of the legislation. In many states, perhaps the majority, the response was comprehensive and the effects on the availability of programs and services for women formidable. Mr. Chairman, your own state of Florida channeled funds to support outpatient, residential and educational services for women.

Continuation of the set-aside is critical for the future of these programs. Continuation grants will be particularly important for women's treatment services, allowing them additional time to establish themselves in communities and to identity additional funding sources.

The National Council on Alcoholism is pleased to pledge its continued support for federal alcohol and other drug research, prevention and treatment initiatives. A strong federal commitment beginning in the early 1970's has made great gains in alcoholism and other drug research, prevention and treatment possible. A continuation and enhancement of that commitment are essential to progress.

Senator HOLLINGS. I appreciate it.

Ms. Lubinski, from your vantage point and experience, what progress have we made in research on alcoholism? We heard only yesterday about the connection between drinking and breast cancer.

Ms. LUBINSKI. Right.

Senator HOLLINGS. Do you have any other examples or any other report of progress made?

Ms. LUBINSKI. Well, I think we have made significant progress in identifying alcohol use as a major risk factor for pregnancy and in developing prevention and education programs that offer that information to women. I think we need a great deal more to do.

I think we ought to label alcoholic beverages and tell women that that is a risk. I want to echo the comments about the genetic connection. I think for years it has been whispered that alcoholism is a family disease, and now we know scientifically that it is, so that if you are a child of an alcoholic you are now in a position to know that you are a high-risk candidate for drinking.

So even without the cure for alcoholism, even knowing about that genetic risk I think greatly affects people's behavior. It might discourage folks who come from families with two alcoholic parents from being drinkers. And I think that is very important as well.

Senator HOLLINGS. Very good. I appreciate your appearance here today.

Ms. LUBINSKI. Thank you very much, Senator.

Senator HOLLINGS. Thank you.

Dr. Perrine, I think, from Boston University School of Public Health.

STATEMENT OF M.W. BUD PERRINE, PH.D., PROFESSOR OF PUBLIC HEALTH AND DIRECTOR, ALCOHOL RESEARCH UNIT, BOSTON UNIVERSITY MEDICAL CENTER SCHOOL OF PUBLIC HEALTH

Dr. PERRINE. Thank you, Senator.

My name is Bud Perrine. In addition to being professor of public health at Boston University's School of Public Health, I am also director of the Alcohol Research Unit, which we moved from Boston and moved up to Burlington, VT, which is my usual home.

And I have been in this area about 20 years, primarily emphasizing the drunken driving problem. And I recall almost 20 years ago when I had my very first alcohol and highway safety research project, for which we were going out to study the incidence of alcoholics and other problem drinkers actually using the roads, and as well as those who are among the fatally injured drivers in highway crashes.

And I needed and received the very active support of the young State's attorney, State prosecutor from our county, who was named Pat Leahy. He is still called Pat Leahy and he is one of your colleagues, as you know, sir, and in fact is on the full Appropriations Committee and is still very actively interested in drunken driving.

Senator HOLLINGS. I just left him 1 minute ago. I will tell him you were here.

Go ahead.

Dr. PERRINE. Thank you.

Annually we lose about 50,000 Americans on the highways in crashes. Of those, half are from alcohol involvement, and those alcohol-involved crashes, about 25,000, represent about 25 percent of all of the alcohol-involved deaths in the country. So we are talking about a major problem.

One could say, well, if the drunken drivers are killing themselves that is one aspect. But in fact, only about one-half of the fatalities are drunken drivers themselves. Another approximately 20 percent are individuals who are neither in the car of the drunken driver nor are they a drinking pedestrian nor are they a driver, the driver themselves who has been drinking.

In any case, this yields about 4,000 truly innocent victims a year from random violence and death on the highway, which is far, far in excess of the loss to international terrorism.

Now, we are making progress. We have been working in this area, as I indicated, for some time. I do not claim any of this progress for our own research, but it may have contributed. We cannot prove these sorts of things.

During the last 4 years, from 1982 to 1985, there has been a proportional 29-percent reduction in the teenagers, 16 to 19 year olds, who have died in fatal crashes above the legal limit, 0.10, a blood alcohol concentration of 0.10. This represents enormous progress.

In our own research, which involves trying to establish the characteristics of drinking drivers ranging across the spectrum from alcoholics on the one hand to social drinkers on the other hand, but emphasizing particularly the youth, we are finding an increasing amount of concern with the combined use of alcohol and drugs and driving.

And this is one of our emphases. We hope to have some results on this in the very near future.

May I just conclude very briefly by mentioning the strong support which we in our field have for the research budget of the NIAAA, the professional judgment budget, which you have heard is $89 million, approximately $20 million over the President's budget.

Now, if I may just conclude with one interesting, ironic juxtaposition between hardware and software. The hardware issues seem to get most of our concern, and we are willing to spend on the order of that same amount of money, $89 million, on one MX missile.

The recent furor over the highway bill, where the appropriation was $88 billion, the issue of the veto was only ten percent of that, $890 million. And again, we are talking about hardware for the highways, without considering the less than one-tenth of 1 percent that would be involved in the alcohol component of that hardware.

The software receives very little attention except in this subcommittee, and we appreciate your support and hope that it does continue.

Thank you, sir.

PREPARED STATEMENT

Senator HOLLINGS. Thank you very much. We appreciate your appearance.

And all the witnesses should know that their full statements in their entirety are being included in the record.

[The statement follows:]

STATEMENT OF M.W. BUD PERRINE

Thank you for the opportunity to appear before you today and to present testimony concerning alcohol abuse research and funding.

My name is Bud Perrine, and I am Professor of Public Health and Professor of Socio-Medical Sciences and Community Medicine in the Boston University Schools of Medicine and Public Health. I am also Director of the Alcohol Research Unit of the latter institution, located in Burlington, Vermont. My training is in the areas of experimental and social psychology.

Regarding relevant professional activities, I have recently been invited by the National Academy of Sciences to serve as Chairman of the Congressionally-mandated study committee to recommend national policy on a statutory blood alcohol concentration limit for commercial motor vehicle operators. In addition, I am a chartered member of the Advisory Committee on Alcohol, Other Drugs, and Transportation recently formed by the Transportation Research Board of the National Research Council, National Academy of Sciences.

Alcohol abuse costs this nation dearly. The annual loss of about 100,000 lives from alcohol abuse represents losing the equivalent each year of all the residents of a medium-size city, such as Miami Beach, Florida. It also costs us more than $116 billion each year; if those dollars could be saved and aggregated, we would not need a Gramm-Rudman-Hollings Bill to fight the national deficit. And all this damage stems from the behavior of citizens who voluntarily drink beverage alcohol, legally and readily available throughout our nation.

We need to know much more about the specific actions of alcohol on the body, on the mind, and on behavior to begin developing and implementing effective and selective prevention measures that will permit the continued voluntary pleasures for so many, yet will avoid the consequent misery for others. To these ends, scientific inquiry and research are absolutely necessary; the National Institute on Alcohol Abuse and Alcoholism is the specific federal agency officially charged with that mission (among others) when it was established just sixteen years ago.

Drunken driving is a major public health problem. Almost 50,000 individuals are killed each year on U.S. highways and roads. That is comparable to losing everyone living in a small city about the size of Lakeland, Florida, each year. And approximately half of these, or 25,000 deaths, result from alcohol-involved crashes. That is comparable to losing everyone living in a community about the size of Key West, Florida, each year.

What categories of individuals die in alcohol-involved highway crashes? Only 52% are the alcohol-impaired drivers themselves, and another 11% are drinking pedestrians. Of the remaining victims, 20% are passengers in the drinking driver's vehicle, whereas 17% are passengers, drivers, or non-drinking pedestrians who were not in the drinking driver's vehicle. Thus, over 4,000 innocent victims (17%) are killed in alcohol-involved highway crashes every year, with another 5,000 victims (20%) killed because they were in the drinking driver's vehicle at the time of the crash. In terms of the 4,000 innocent victims, then, that is roughly comparable to losing the Boston Celtics starters and their backups -- every day -- because of being killed by drunken drivers. But the point of these collective examples is that any one of us here in this room or anywhere else in this nation could be killed by the random violence of a drunken driver crashing into us as we innocently use the highways or sidewalks throughout America.

The drunken driving problem is exceedingly complex. It cannot be solved with slogans (for example, "Friends don't let friends drive drunk", "Stop drunk driving", etc.). It cannot be solved by the prohibition of alcohol, as in the Great Experiment. Our major hope is based on achieving the three goals of science: increased understanding of the phenomenon, leading to increased prediction regarding the phenomenon, leading in turn to increased control of the problem. The key to understanding -- the first link in this chain -- is high quality research focused on drinking drivers.

Research on drunken driving is making progress. The rate has been quite slow, however, due in part to the extraordinary complexity of the phenomena and in part to the lack of predictable research funding that would in turn facilitate a coordinated systematic approach to the problem. Let me address the complexity issue here and the funding issue later.

Almost every American uses the highways, either as a driver or as a passenger. Most of us also use the sidewalks or roadsides as pedestrians or cyclists. Just in terms of the sheer number of drivers in America, the magnitude and complexity of this problem area are overwhelming. The vast majority of Americans also drink alcoholic beverages. A large proportion of Americans do both: they drive after drinking; some do so after 1 or 2 drinks, some after 5 or 6 drinks, and some after 10, 20, or 30 drinks. Thus, there are an enormous number of possibly relevant variables and contributing factors in this problem area.

We have already established the importance of age differences; for example, alcohol-involved crashes are the leading cause of death for teenagers (ages 15-19); and when alcohol is involved, the fatal crash rate of young drivers is three times that of older drivers. Thus, experience with driving, experience with drinking, and experience with driving after drinking are all possible components in understanding such age differences. Other factors possibly associated with different crash rates among drinking drivers might well be differences in attitudes, differences in personality, differential sensitivity to alcohol actions on behavior, as well as even genetic predispositions to be able to tolerate alcohol effects. Recent research on some of these variables has been useful in differentiating among broad types of drinking drivers. Thus, further research along these lines should be productive in increased refinement and differentiation among high-risk versus medium-risk versus low-risk drinking drivers.

The great complexity of research on this real-world problem of drunken driving causes it to be costly. However, we need a higher not a lower level of funding to assure continued progress and to develop effective means for selectively targeted prevention. The complex object of study is embedded in two of our most frequent activities, namely, driving and drinking. Valid conclusions about the interaction between these two frequent activities cannot be obtained by studying them in isolation or just in the laboratory. Rather, it is necessary to go out of the university, to go out into the field, to observe and interview drinking drivers, and to work with the police and others involved with this problem in the real world.

The contributing factors and significant variables must be teased out painstakingly from the complexity of the whole problem. Furthermore, the more complex the phenomenon, then the larger the number of subjects needed for adequate differentiation and for statistical significance. Field research that addresses a major public health problem of this magnitude is much more costly than laboratory research on isolated variables (e.g., alcohol effects upon reaction time in a psychomotor task). Any attempt to force cost containment on such field research would thus be both stifling and counterproductive. Ultimately, the nature of the problem drives the nature of the research--and that should in turn determine the nature of the costs.

If the FY 1988 research appropriation for the NIAAA is not increased as recommended by the Professional Judgment Budget, but rather is decreased as in the President's request, then the funds available for real-world field studies concerning drinking and driving will not be adequate to support meaningful research on this problem. If the appropriation is as restricted as in the President's request, the already small number of grants and specialists in this crucial public health research area will diminish further. Unfortunately, there are currently so few really dedicated and talented scientists in this area that we cannot afford to lose any at all. On the contrary, we desperately need to attract more new research talent to the alcohol abuse area in general and the drinking-and-driving area in particular.

To provide research continuity and program predictability, we must also resist cutting the NIAAA research appropriation in subsequent years. Rather than reducing, we should be building; and we should be training new researchers in this important public health problem area.

Consequently, I strongly support the Professional Judgment Budget for the FY 1988 NIAAA appropriation and thus oppose the counterparts in the President's budget. Among other effects, adoption of the reduced appropriation as recommended in the President's budget would permit NIAAA to fund only 89 new and competing grants, which is 11 fewer than the level of 100 appropriated by the Congress in FY 1985 and FY 1986 and 28 fewer than in FY 1987; it would also require cuts in the average costs of the new and competing grants. In the process, it would greatly reduce the flexibility the NIAAA needs in funding grants of varying magnitudes of cost.

The FY 1988 recommendation in the Professional Judgment Budget for alcohol research is $89,513,000. This proposal stands in contrast to the President's FY 1988 request of $68,876,000 for alcohol research. If adopted, the proposed Professional Judgment Budget would provide a 20% increase in the number of research grants supported by the NIAAA. If adopted, this proposal should also be followed by scheduled increases of approximately the same magnitude each year through 1990 in order to facilite the necessary and appropriate growth in the number of grants funded annually. This proposal would also provide for awarding 130 new and competing grants (rather than 89) at levels recommended by the peer review committees (the so-called Initial Review Groups) and the National Advisory Council. Further, this proposal would also provide adequate funds to allow at least a small number of grants to be awarded with a larger average annual cost so that some of the important, but more costly projects could in fact be undertaken in the future.

As an active member of the American Psychological Association, I also strongly urge support for the recommended appropriations of $330,000,000 for the National Institute on Mental Health and $183,000,000 for the National Institute on Drug Abuse.

In conclusion, the costs of research on drunken driving and other alcohol abuse are extremely small relative to the potential savings in lives, suffering, and dollars, especially when compared to the costs of other federal expenditures, many of which do not have a similar potential for such savings. In view of the increased competition for decreasing federal funds, some criteria should be available to aid in reaching rational decisions on the relative priorities for appropriations. Very compelling criteria for this purpose would be the potential number of American lives saved, the number of injuries prevented, and the number of dollars thus spared. Research on alcohol abuse in general and on drinking and driving in particular clearly meets these criteria. The potential for both human and economic savings in this major public health problem area is enormous.

STATEMENT OF MARCUS A. ROTHSCHILD, M.D., PAST PRESIDENT, AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES

Senator HOLLINGS. We next have Dr. Rothschild.

Dr. ROTHSCHILD. Thank you, Senator. And I remember your excellent discussion in front of the research society a couple of years ago in South Carolina, and I appreciate it.

Senator HOLLINGS. Thank you.

Dr. ROTHSCHILD. My name is Dr. Marcus Rothschild and I come from New York and, in addition to being involved in alcohol, I am the immediate past president of the American Association for the Study of Liver Disease, and, therefore, I have an interest in both aspects of this terrible problem.

Shortly, the sixth special report given to the U.S. Congress on "Alcohol and Health" by the Secretary of Health and Human Services will be delivered. This detailed document clearly points out the continuing tremendous problems of alcohol.

And as you have heard, Senator, 18 million Americans over the age of 18 suffer from alcohol abuse or alcoholism. Alcohol-induced diseases constitute major causes of hospital admissions and complicate many other unrelated diseases. Liver cirrhosis, for example, is one of the leading causes of death, and there is still no effective treatment for this hepatic disorder.

Hundreds of thousands of dollars may be spent treating the complications occurring in a single patient. Alcohol affects every function of the human body, and it is the major disorder clearly relating an environmental stress, namely alcohol, in a genetically predetermined sensitized or sensitive individual.

This situation offers unique possibilities for examining the interrelationship of these two factors which probably underlie the causation of all disease. Major advances, as you asked, have been made in many areas of alcohol-induced organ damage and alcoholism.

There is new information which leads to our understanding of the genetic control of the enzymes responsible for the metabolism of alcohol in the liver. There are new data on how alcohol influences signals in the brain and how alcohol interferes with the membrane or cell lining.

Small concentrations of phosphorus-containing fats may appear to play an important role. Our newer understanding of how the liver transports protein may aid in understanding how alcohol interacts with liver cell function, and we are beginning to understand how alcohol and nutrition interact and can affect the unborn fetus.

This work has been performed by investigators funded by different sources, but the major source is the National Institute of Alcohol and Alcohol Abuse. And therefore, I add my voice to those who have preceded me, so that basic investigation into this disease, a disease so disastrous in affecting so many millions of us, may be expanded.

Treatment based on inadequate knowledge is always ineffective and expensive, and the basic investigation must precede the directed research before appropriate clinical studies aimed at alleviating this disorder or any disorder can proceed.

PREPARED STATEMENT

I thank you very much for giving me the opportunity to present my views to you today.

[The statement follows:]

STATEMENT OF MARCUS A. ROTHSCHILD

My name is Dr. Marcus A. Rothschild, Director of the Nuclear Medicine Service, Veterans Administration Medical Center, New York at 1st Avenue and East 24th Street. I am also Professor of Medicine, NYU Medical Center, immediate Past President of the American Association for the Study of Liver Diseases, Editor of the Journal "Alcoholism: Clinical and Experimental Research", the main scientific peer review journal in the field and the recipient of the Research Society on Alcoholism's Annual Award for Scientific Excellence, 1986. Our research is aimed at determining how alcohol exposure (acute or chronic) and how the metabolism of alcohol interferes with hepatic protein synthesis and secretion and cardiac muscle protein production.

I am an active member of the Research Society on Alcoholism because I am convinced that we must have a greater research effort.

Alcoholism and alcohol-induced organ injury continue to be one of the most malignant public health problems that our nation faces. The cost in human suffering, physical disease, defective workmanship accidents and crime is staggering and the estimate from the Research Triangle Institute, N.C. (1984) is in excess of $116 billion per year. We are facing a problem to which there is no answer at present. We do not understand why certain individuals can become addicted so early and so seriously to this small molecule whose metabolic pathway we so clearly understand. Although we understand some of the toxic manifestations of alcohol, such as the production of acute inflammation in the stomach and the pancreas, we are at a loss to explain why some people who drink get significant liver disease while most who drink do not.

It is perfectly true that we have a much stronger commitment to the concept of alcoholism as a disease and we have organized treatment modalities which attempt to alleviate the psychological and addictive processes as well as treat the organ damage. A successful treatment outcome is very hard to obtain and so frequently the patient relapses not for just a short period of time, but with a consequence that leads to further physical and environmental destruction mentioned above. Cirrhosis of the liver is an example of physical change due to alcohol consumption and there is no effective treatment for cirrhosis of the liver. Certainly, it is true as with diabetes or gout, that if we can maintain a sick individual working and being partially effective for let us say half a month at a time, it is certainly an improvement. Yet again, as with diabetes and gout, the patient is never free from his disorder and the consequences of a relapse are most serious.

History has demonstrated that disease can be conquered if the right questions are asked and the platform for the "right questions" was, is and will be basic research. Our best hope to create opportunities for these questions to be asked is to stimulate basic investigation into the causation of the problems related to alcohol consumption. For example: Why does alcoholic hepatitis develop in only certain alcohol drinking individuals? What is the addictive process to alcohol? Answers are not yet apparent since the specific detailed concepts are not defined. However we have begun to make some significant progress in many fields. For example, acetaldehyde, the primary product of alcohol metabolism has been recently shown to act as a specific stimulator to antibody production and these antibodies may in turn be responsible for producing and perpetuating organ damage. Further, the presence of acetaldehyde bound to protein may act as a marker for drinking just like glucose which bound to the hemoglobin molecule, will indicate the degree of control in the diabetic patient over many months prior to his or her examination.

New observations have been reported concerning specific phosphorus-containing compounds which may confer a degree of tolerance to alcohol in biologic membranes has and therefore conceivably could lead to markers which would identify those patients who are at risk.

How do we exploit these new data which are being developed in our laboratories? We need to encourage those scientists now at work by giving them the security of continuing funding efforts have earned them. We also must stimulate the interest of investigators who are submitting initial grant requests and the Professional Judgment Budget would be a positive action in accomplishing this aim. It is the new, potentially innovative concepts which study sections find so intriguing and thus award appropriate meritorious scores. Yet the NIAAA is still unable to fund all such grants even though they are carrying priority scores in the 100 range. There is nothing more disturbing to an investigator who has devoted his training and now his thinking towards new ideas, to receive an outstandingly solid review by his peers and then be told that he cannot be funded. How many times can we turn off the potentially effective investigator before he or she walks the other way?

As another parallel effort we should now try to attract more investigators into the field. A mix of applied and basic investigation is the ideal. The applied is necessary to exploit and advance the new concepts born from the basic studies. The concept of only applied research to find a cure for something, has always proved to be ineffective in the absence of basic knowledge. What is suggested is to attract other good scientists to consider the inclusion of alcohol in their investigative efforts. This will not diminish the basic nature of their studies but could conceivably add another parameter. The Veterans Administration has attempted this in the past with excellent success and at a limited cost and new and innovative programs have been funded and investigators have made significant contributions. One such individual who was funded is Dr.Boris Tabakoff who is now the Science Director of the National Institute of Alcohol and Alcohol Abuse.

There are other problems in stimulating alcohol research from the ground up. A great deal of effort must come from the medical schools. So little curriculum time and attention is paid to this tremendous problem. The lack of Chairs in the study of alcohol related diseases throughout the country attests to the limited scope that this tremendous problem has been given.

For a disease and disease syndrome which is so disruptive and expensive to our national existence to receive such a small fraction of our scientific money, appears to me to be short-sighted. Additional grants may be given and efforts can be organized to bring into the field more fine science.

Finally, this effort should not be made at the expense of the sick patient. Clearly, we still must have concern for his or her rights and problems but we must realize that we will continue to be relatively inept and ineffective in most of our alcohol treatment efforts unless we know more about the disease we are treating and to do this, we must stimulate education, research opportunities and secure the research future for the top-flight scientist.

Senator HOLLINGS. We thank you, Dr. Rothschild.

What is the cause of alcoholism?

Dr. ROTHSCHILD. Well, the cause of alcoholism is a combination of somewhere in our body we are genetically predetermined to have this and obviously then we drink. You can be predetermined genetically sensitive and not drink and not suffer the immediate disastrous causation of the diseases.

And why this idiotically simple molecule, whose metabolic schema we know so well, can cause such disastrous problems is clearly unknown. We do not know what addiction is and we do not know why the metabolism of this material as yet produces organ damage.

And that is why we need to combine the efforts not only in the genetic field, but in the study of organ damage per se, to try to put these two together. And this is why basic investigation is clearly needed, and we have the tools now to begin to do this.

But I cannot answer your question.

Senator HOLLINGS. I just wonder. You have been in it for many more years than me, and I started back in the forties with all of the different groups, and we are still struggling and have not put too much together on it. I mean, I agree with you, genetically. I know members of families and you can tell it right now, they take one drink and they are gone.

Thank gosh, if I take one I am not. But then there is a difference in age, and chemistry must change, because I remember when I was like a young marine I could take many more. Now, I get a hell of a headache, thank goodness, and I cannot work the next day.

So I do not right now. It is not any moral thing with me. It is just, by gosh, I cannot get my work done.

Dr. ROTHSCHILD. The mortality rate for cancer is just what it was 40 and 50 years ago, and we have put an awful lot of money into that. We have not asked the right intelligent question of nature as yet to come up with the appropriate answer.

But that does not mean we should not continue to investigate the causation of cell multiplication or genetic transformation. It means that I think that we should put more effort into it, not less.

Senator HOLLINGS. Well, I am with you. I just want you to give me a cause.

Dr. ROTHSCHILD. I wish I could, sir.

Senator HOLLINGS. Well, you have been in it for years, listening to everybody and what have you.

There seems to be a tremendous development with respect to chemicals in the treatment of mental health.

Dr. ROTHSCHILD. Well, that is based upon the fact—I mean, the answer is yes, we certainly can alleviate the pain of mental disease.

Senator HOLLINGS. There is something that you cannot receive in America under Food and Drug that you can in Canada, England, and different countries.

Dr. ROTHSCHILD. Well, I think that is a safety valve over here. We have had many problems. Thalidomide is only just one of the ones that many years ago raised its ugly head after it was administered too soon.

But the understanding of how the brain cells interconnect is the basic investigation which stimulates the increment in use of newer chemicals or drugs to interfere with its transmission and therefore alleviate some of the symptoms in acute depression and other diseases.

But we cannot alleviate pscyhosocial aspects. We cannot change the psychopathological individual, and we can only minimally alleviate some of the signs and symptoms in other diseases. There is a long way to go there, tool

But all of that stems from a basic understanding of how one cell interacts with another and signals it.

Senator HOLLINGS. Very good, sir. Thank you very much.

Dr. ROTHSCHILD. Thank you.

Senator HOLLINGS. Is Dr. Lewis here, the director from Brown University of the Center for Alcohol Studies?

[No response.]

Senator HOLLINGS. Ting-Kai Li, a doctor from Indiana. Very good. We welcome you to the committee.

STATEMENT OF TING-KAI LI, M.D., INDIANA UNIVERSITY SCHOOL OF MEDICINE

Dr. LI. Thank you, sir. Senator Hollings, staff members of the subcommittee. I am Ting-Kai Li, a professor of medicine at the Indiana University School of Medicine. I am also the president of the Research Society on Alcoholism, which has an active national membership of more than 500 doctorate level scientists.

Our common interest is the development of knowledge applicable to the detection, prevention, and treatment of alcohol abuse and alcoholism. It is the only professional society in the field of alcohol research, and I am pleased to appear before this subcommittee on behalf of the at-large membership of this society.

First, Senator Hollings, I would like to thank you and your home State, as the previous speaker, for hosting the annual meeting of our society at Wild Dunes in 1985. Currently we are scheduling the 1988 meeting to be at the same site, with Terry Randall being the organizer, and I would like to offer you an early invitation to again open that meeting, and then also to witness first-hand the advances that have taken place since the last meeting.

Senator HOLLINGS. Very good. I look forward to it.

Dr. LI. Second, I would like to thank this subcommittee for the support it has given to alcoholism research in the recent years. However, in spite of your and our best efforts, the allocation of Federal research dollars for alcoholism-related research, which comes principally from NIAAA, remains miniscule.

It is noteworthy, however, in spite of this low level of funding, there have been impressive gains in alcoholism research in the last decade, and an excellent review of the progress in the field is the recently released sixth special report to the U.S. Congress on alcohol and health, from the Secretary of Health and Human Resources.

And I would like to bring this report to your attention, and in the event that you have not received it I am leaving a printed copy of this here for your perusal. This is the document here.

Some of the major research advances have been and will be cited by other investigators who follow. Now, one of my own research areas of interest is the genetics and biochemical basis of abnormal alcohol-seeking behavior. We have found that animals, research animals that show this behavior also have an abnormally lowered level of the neurochemical substance serotonin in the brain.

Studies in these animals have shown that drugs which raise the level of this neurotransmitter compound in the brain ameliorate the alcohol-seeking behavior. These findings have important implications for the treatment of alcoholism, and the treatment trials in humans with these drugs may be initiated in the very near future.

Now, the President's fiscal year 1988 request for NIAAA is only $81.7 million, of which $6.68 million would be for research. These amounts are lower than the 1987 appropriation and considerably lower than the fiscal year 1988 current services budget, which is $97 million. The President's request therefore would require not only drastic curtailment in the number of new and competing grants, but it would also cut the budget of ongoing grants.

The Research Society on Alcoholism supports the 1988 budget for NIAAA of $111 million, of which $89 million would be for research. This amount would restore funding of current projects to council-approved levels and provide some modest growth.

PREPARED STATEMENT

We believe that the momentum that this subcommittee has helped generate in our alcoholism research should not be allowed to dissipate, and we hope that you will continue to support the growth of alcoholism-related research which is so very much needed.

Thank you, sir.

[The statement follows:]

STATEMENT OF TING-KAI LI

I am Ting-Kai Li, Professor of Medicine and Biochemistry at the Indiana University School of Medicine. I am also the President of the Research Society on Alcoholism, which has an active national membership of more than 500 doctorate level researchers. Our common interest is the development of knowledge applicable to the detection, prevention and treatment of alcohol abuse and alcoholism. It is the only professional society in the field of alcohol research. I am pleased to appear before this Subcommittee to represent the concerns of its membership regarding the President's proposed FY 1988 appropriations for the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

I know that the members of this Subcommittee are well-aware of the extent, seriousness and multibillion dollar economic cost of the health and social consequences of alcohol abuse and alcoholism. Paradoxically, the allocation of federal research dollars for alcoholism-related research, which comes principally through NIAAA, is minuscule. The current NIAAA research budget is less than 1.5% of the total appropriated for NIH and ADAMHA. It is only about 6% of that allocated for cancer and about 9% of that for Heart, Lung and Blood. The dollars being spent on alcoholism research is less than that for dental research.

It is noteworthy that, in spite of this low level of funding, there have been impressive gains in our area of research interest. An excellent review of the progress in the field is the recently released "Sixth Special Report to the U.S. Congress on ALCOHOL and HEALTH" from the Secretary of Health and Human Services. Among the major research advances are:

1) The discovery of genetic predisposition to alcohol abuse and alcoholism in at least 40% of afflicted individuals.
2) The discovery that genetic predisposition and environmental factors can interact to affect severity of the disorder. This finding has important implications for the development and assessment of treatment and prevention strategies.

3) The demonstration that as a group, children of alcoholics differ from children of nonalcoholics in neurophysiological and neuropsychological testing, both with and without a test dose of alcohol. These findings may serve as "markers" of individuals more at risk in developing alcoholism than others
4) The finding that there is tremendous between-individual differences of genetic and biological origin, both in humans and experimental animals, with regard to responses to alcohol, e.g., the amount of alcohol necessary to produce impairment of function, the ability to develop tolerance and physical dependence, and the rate of metabolism of alcohol. Understanding of the biological basis of these phenomena are important to the development of effective strategies for alcohol-problems and alcohol dependence.
5) The discovery that genetic differences in the enzymes of alcohol metabolism can affect drinking behavior and hence, the development of alcoholism. For example, the genetic absence of one of the forms of aldehyde dehydrogenase has been shown to be a negative risk factor for the development of alcoholism.
6) The development of animal models to study the genetic and biological mechanisms of alcohol intoxication, tolerance, and dependence.
7) The development of an animal model of alcoholism itself through genetic selection for unusually intense alcohol-seeking behavior. In fact, these animals exhibit an abnormally lowered level of the neurotransmitter serotonin in certain brain regions. Studies have shown that drugs which raise the level of this neurotransmitter in brain ameliorates the alcohol-seeking behavior of these animals. These findings have important implications for the treatment of alcoholism which is a behavioral disorder characterized by aberrant alcohol-seeking behavior.

There are many other, exciting recent advances. For example, the enzymes of alcohol metabolism in human liver have now been purified and characterized. The genes for these enzymes have been characterized and current research is directed at identifying how these genes are regulated and whether enzyme patterns can be markers of predisposition to alcoholism. All of these advances promise rapid gains in our understanding of the biology of alcoholism in the near future, and a sustained increase in research funding is needed. Otherwise, the momentum and excitement in the field that has recently developed will slacken.

The President's FY 1988 Request for NIAAA is only $81.7 million, of which $68.8 million would be for research. These amounts are lower than the FY 1987 appropriation and considerably lower than the FY 1988 current services budget, i.e., $82.1 million for research and $97 million total. The President's Request would require not only drastic curtailment in the number of new and competing grants, but also cuts in the budget of ongoing grants. These kinds of cost-saving measures are short-sighted and exceedingly damaging to major scientific efforts at finding better treatment and prevention approaches to a health problem that affects 18 million Americans and costs the nation more than 100 billion dollars overall.

The Research Society on Alcoholism, the APA, and other groups are recommending a 1988 budget for NIAAA of $111.4 million and 234 FTEs. This is an increase of $29.7 million and 40 FTEs over the Administration's request of $81.7 million and 194 FTEs. Of this amount, $89.5 million would be for research. The increase of 40 positions are to alleviate what we see as a serious understaffing in both intramural and extramural programs. The understaffing has resulted in many missed research opportunities in both intramural and extramural research. In addition, RSA supports the professional judgement budget proposal for the other ADAMHA Institutes which would provide $330.0 million for NIMH research, $183.0 million for NIDA research, and $32.0 million for the research training program of the three Institutes. In addition, RSA supports funding the ADM block grant program at $650.0 million, supplemental treatment grants at $195.0 million, and service demonstrations at $24.0 million

The recommended amount for alcohol research would provide an increase of $9.2 million for the investigator-initiated grant program to restore projects to Council-approved levels and provide for an increase of eleven new grants. It would also provide $17.1 million for needed growth in the other research programs, including Centers, Career Development Awards, and an instrumentation grants program. An additional $2.6 million and 21 positions would allow the Intramural Program to expand its efforts in research utilizing NMR to study the process by which alcohol creates damage in infants born to alcohol-abusing mothers and, through advanced techniques in molecular genetics, to study biological susceptibility of certain individuals to alcoholism. An additional $2.8 million and 19 positions are needed to meet the shortfall in direct operations and to restore contract efforts in research dissemination, maintenance of data base, and technical services activities which have been cut back or postponed because of budget constraints.

In the training area, we are recommending an increase of $1.6 million to increase the number of research trainees from the 125 provided by the Administration's request to 203 trainees. We are also recommending a restoration of the clinical training program with $1.0 million.

Four decades of fruitful sponsorship and execution of quality research programs have helped us conquer various diseases and improve our quality of life. Significant scientific advances as well as fundamental discoveries do not occur by happenstance. They are the direct result of a 40-year partnership between government and research scientists. While I fully recognize the current need to balance the budget, an increase in funding for alcohol research will undoubtedly be cost effective in the long term. I would urge you to consider increased funding for alcohol research and training in 1988 at the level of $11.4 million and 235 FTEs as well as providing the professional judgement budget proposal for the other ADAMHA Institutes and the ADM block grants.

Thank you.

Senator HOLLINGS. Thank you, Dr. Li.

That report, I had not seen that, and you are answering the questions I have been asking the other witnesses: Just what have we found out in all of this research and what progress have we made? Evidently you are making some progress.

Dr. LI. Yes, sir.

Senator HOLLINGS. And that is all contained when you talk about the lower level of the neurotransmitter of serotonin in the brain. That is interesting.

Dr. LI. I think this will be probably one of many abnormalities that we will find.

This kind of research advance has come about because of continued support by NIAAA of the development of genetic animal models that would allow us to study this kind of alcohol-related behaviors, and I think you will hear more about this kind of research from other witnesses this afternoon.

Senator HOLLINGS. It is an interesting development, because I remember in the early days you would not get the responsible doctors like yourself to identify with alcoholism. Alcoholism was a moral degeneracy.

I had a Governor and former Senator and former Secretary of State, Jimmy Burns, I can hear him right now, telling me that alcoholism came from not drinking 100 proof bonded bourbon. And he said, you drink that trashy James Walsh and everything else, and he would pull out some Old Fitzgerald and want to drink 100 proof bonded bourbon, and that prevented alcoholism, and he really believed that.

You are getting 500 doctors, you say, associated now, is that right?

Dr. LI. Yes, sir.

Senator HOLLINGS. And how many centers are doing that kind of research? Is it all over the country or in particular places? And do I have any research in alcoholism in my State?

Dr. LI. Oh, yes, sir.

Senator HOLLINGS. I have Jerry McCord and his whole movement there. What kind of research have I got, where?

Dr. LI. Well, I think the research in South Carolina, the most prominent researcher is your friend Terry Randall. She has been one of the major contributors to understanding of the fetal alcohol syndrome.

Senator HOLLINGS. Well, that is true.

Well, very good, Dr. Li. We appreciate it, and we appreciate the report.

Dr. LI. Thank you.

Senator HOLLINGS. Our next witness is Dr. Lieber of the VA Medical Center in the Bronx. We welcome you to the committee, Dr. Lieber.

STATEMENT OF CHARLES S. LIEBER, M.D., ALCOHOL RESEARCH AND TREATMENT CENTER, VA MEDICAL CENTER, BRONX, NY

Dr. LIEBER. Thank you, Senator.

My name is Charles Lieber. I am professor of medicine and pathology at the Mount Sinai School of Medicine of New York and Director of the Alcohol Research Center, and also chief of the section of——

Senator HOLLINGS. Now, you have been engaged in research for 30 years. What have you found out?

Dr. LIEBER. Now, my interest originated from the fact that most of my patients with liver disease are alcoholics, and therefore I wondered, what can we do for them. Now, usually what is being done is that we treat their complications.

The major problem is scarring of the liver or cirrhosis and, as you heard, it is an important problem in urban areas, and it is the third cause of all deaths, No. 3 of all deaths in the active age of 25 to 65.

In addition, it has a high morbidity. Patients die of bleeding. They have retained water, they have mental problems. And physicians usually help them deal with those complications, but of course that is too late. We cannot restore them to normal.

However, not all heavy drinkers go on to develop these severe complications. Therefore, it would make sense that, at least it would appear to me that way, to try to act at an earlier stage, before the medical or social disintegration of these patients.

And since not all heavy drinkers go on to develop these complications, obviously what we had to try to do was to identify those subjects who are particularly prone to develop these complications, because we could treat them at that early stage. We could still hope to prevent the major complications.

And we have made some progress along those lines. We have been able to identify in the liver a change, a lesion, that enabled us to detect those subjects who, upon continuation of drinking, are particularly susceptible to develop these major complications.

Now, at this time a liver biopsy is required to detect the lesion, but there is some hope that a blood test can be developed to obtain the same information.

Obviously, a blood test would be needed to transfer this type of information to a larger segment of the population and to implement what I would like to hope to see happening, namely a public health approach to the problem, namely detection at an early stage in the large segment of our population.

Obviously, what we need is more research, accelerated research, in the development of these factors, including genetic factors.

Senator HOLLINGS. To try to find that out in a regular blood test?

Dr. LIEBER. We have now some blood tests that give us part of the information, and we hope that further research will make it practical for the field. But what is needed now is more research to apply this knowledge.

So the blood test we have now developed allows us to detect it in 75 percent of the subjects. Our liver test, the liver biopsy, allows a detection of almost all subjects. So the information is there, but what we need is more research to apply it and to find practical ways to apply it, and then we can indeed sharply decrease, I believe, the impact of the severe complications.

Moreover, further basic research would allow us to directly act on the scarring tissue. We have isolated from the liver a cell which makes the scar tissue, and by learning what turns that cell on we have some hope we can eventually turn it off as well.

So what we need is more support. As you know, the budget proposed by the President would actually decrease the support we are getting, whereas the professional judgment budget would allow us not only to continue our research, but also to expand it, albeit in a modest way.

PREPARED STATEMENT

It should be pointed out, for instance, that research has been carried out at a less than optimal level because of less than optimal funding. And I know personally of many worthwhile projects that have not been carried out because of lack of funding.

[The statement follows:]

STATEMENT OF CHARLES S. LIEBER

I am a professor of medicine and pathology of the Mt. Sinai School of Medicine and Chief of the Alcohol Research and Treatment Center and Section of Liver Disease and Nutrition at the Bronx Veterans Administration Medical Center, NY. I have been associated with these institutions since 1968 and I have been engaged in alcohol research for over 30 years, during which time I have written more than 600 research papers and 4 books. I have been a cofounder and the first president of the Research Society on Alcoholism which groups the majority of biomedical and behavioral alcohol researchers in the country. I am testifying on behalf of that organization which has been created "to identify and assess research goals and needs regarding alcoholism and alcohol-related problems and to promote the quality of research in these fields."

Much of my research has focused on hepatic complications of alcoholism, because most of my patients with liver disease are alcoholics. Furthermore, 75 percent of all medical deaths attributable to alcoholism are due to one complication, namely cirrhosis, or scarring, of the liver. Moreover, in urban areas, cirrhosis of the liver is now the third cause of all deaths in the active age group 25–64 years. Although not all patients with cirrhosis are alcoholics, in the United States, a vast majority of cirrhotics do admit to excessive drinking. Not all heavy drinkers, however, develop this severe form of liver disease. Estimates vary between 10 to 40 percent, depending on the individuals' susceptibility, as well as the duration and amount of alcohol intake. Once cirrhosis develops, however, it is irreversible and commonly associated with severe complications such as internal bleeding, excess fluid accumulation, and alteration of brain functions, all of which can lead to severe morbidity requiring extensive hospitalizations and eventually resulting in a high mortality. At present, the bulk of medical intervention is focused on the palliation of these severe complications. However, since not all heavy drinkers go on to develop cirrhosis, it would make sense to try to define, at an early, precirrhotic stage, those subjects who are particularly prone to develop these severe complications. Furthermore, since not all heavy drinkers are similarly affected, it is obvious that factors other than alcohol, particularly genetic ones, are involved. Although genetic information may eventually result in effective ways to identify, at early stages, those individuals most susceptible to develop the severe aspects of alcoholism and its related complications, the process of screening susceptible individuals at an early stage and to subject them to active intervention does not have to wait for the full elucidation of the genetic component. Sufficient empirical observations have accumulated to allow already at the present time for the development of an effective public health strategy based on the early identification of individuals at high risk. By focusing our therapeutic efforts on those susceptible individuals prior to their medical or social disintegration, at a time when their medical disorders are still fully, or almost fully, reversible, such an approach might significantly reduce the most severe medical disorders associated with excess alcohol consumption and thereby decrease the associated suffering to the patient and the huge costs to society. Two breakthroughs in alcohol research with which I have been associated will serve to illustrate the contention that enough scientific information has now been developed to justify resonable expectations of success in the foreseeable future based on the approach outlined above, if sufficient support is made available.

Two decades ago, I started research on the effects of alcohol in a baboon colony and I have been successful in developing the first and thus far unique model of alcohol induced liver disease, including cirrhosis, in the baboon. These studies established the fact that alcohol can produce cirrhosis even in the presence of an adequate diet and thereby proved a direct link between alcohol and the development of cirrhosis, independent of nutritional factors. Once this model was established, further studies—spread out over a decade—allowed us to define precirrhotic lesions in the liver. We discovered that in those baboons which eventually develop cirrhosis, lesions appear in the early precirrhotic stages characterized by a fibrous rim of scar tissue around the central venules of the liver. If alcohol abuse is stopped at that stage, the lesion does not progress and, for all practical purposes, the liver continues to function normally. However, if alcohol abuse continues, animals with this lesion will rapidly progress to more severe stages, including cirrhosis, whereas those without the lesion do not, despite a comparable amount and duration of alcohol intake. We have now confirmed the prognostic value of this lesion in a human study conducted over an 8-year period. Alcoholics who all had a fatty liver—the first, fully reversible, stage of alcoholic liver disease—divided into two groups according to whether or not they had this perivenular fibrosis. Nevertheless, those with the lesion progressed rapidly to more severe stages, including cirrhosis whereas those without the lesion, with one exception, had no significant or very slow progression. Thus, we now can identify at an early precirrhotic stage those subjects prone to develop the more severe lesions, including cirrhosis, upon continuation of drinking. At present, liver biopsy is required to detect the precirrhotic marker but here is promising ongoing research to establish a blood test that may provide similar information through the measurement of circulating breakdown products of the scar tissue. A related promising area of research is a better knowledge of what promotes the scarring process. We have not succeeded in isolating cells from the liver capable, in the test tube, of producing collagen, the typical matrix of the scar tissue. Through more intensive studies, there is a reasonable hope to define the biochemical and genetic factors that promote the production of scar tissue by these cells. Once we find out what turns these cells on, there is a good prospect that we could also develop means to turn them off and to effectively stop and perhaps even reverse the scarring process. Thus, at present, more intensive research would accelerate the establishment of an effective preventive strategy against cirrhosis, the major complication of alcoholism, by accelerating the development of a blood test allowing for screening, and early treatment. What is also needed is the funding of comprehensive programs aimed at applying and testing this knowledge under carefully controlled conditions.

A newly discovered pathway for the breakdown of alcohol represents another promising line of inquiry. Alcohol is precessed through two pathways, one involves an enzyme, alcohol dehydrogenase, the genetics of which has been extensively studied and defined. The other pathway has been more recently discovered. We have shown that after chronic alcohol consumption, there is increased activity in the liver of an enzyme, a microsomal cytochrome P–450, which is uniquely related to alcohol. This increased activity explains how chronic drinkers produce more of the toxic metabolite of alcohol, namely acetaldehyde. In addition, this specific alcohol inducible form of cytochrome P–450 has the unusual capacity to activate a variety of other potentially toxic compounds present in our environment. It strikingly enhances the toxicity of ubiquitous industrial solvents, commonly used anesthetics, medications and over-the-counter analgesics; it is also effective in activating chemical carcinogens. Thus, this newly discovered pathway can explain the increased susceptibility of the heavy drinker to the toxicity of many environmental agents, drugs and even some vitamins such as vitamin

A. This alcohol inducible cytochrome P–450 has now been identified not only in a variety of rodents and subhuman primates, but also in man, with the demonstration of an increased content after chronic alcohol consumption. It is not known, however, whether some individuals have an inherited difference in their base level of this cytochrome P–450 and whether genetic factors influence the degree of the inductive response to alcohol. Methodology has now become available to define the genetics of this new pathway and possibly to detect individuals predisposed to mount an unusual response—including liver damage—as well as to assess environmental factors that contribute to the severity of the associated medical complications.

The areas of promising research cited here are mere examples of many other breakthroughs which are now ripe for practical applications, if adequate funding becomes available. Although funding of alcohol research has been significantly improved by the creation of the NIAAA and its research efforts, particularly those channeled through the National Alcohol Research Centers, funding is still surprisingly low compared to other research efforts in the health field, particularly if one takes into account the magnitude of alcoholism and the associated medical and social consequences. Therefore, I strongly support the professional judgment budget for fiscal year 1988 which in a modest, but effective way would alleviate, in part, the dire lack of funding which hampers progress in many promising areas of alcohol research. Specifically, by providing $111.4 million, a 20-percent increase in the number of research project grants supported by NIAAA would be possible and promising research projects could be carried out. I personally am aware of a number of high quality projects proposed by very capable investigators that cannot be initiated because of lack of funds. It is particularly important to provide funds for new and competing research projects that might address high priority research areas. In the field of alcohol research, a major impact has been achieved in recent years through the existing alcohol research centers. For much of the time however, these centers were not funded at the approved level and, therefore, had to function in a less than optimal way. Full funding and expansion of these existing centers would be most cost effective. Other worthwhile projects include the expansion of the intramural research and building program, the upgrading of alcohol research laboratories, and an increase in the support of trainees needed to ensure the future supply of well prepared individuals.

On the basis on my 30-year commitment to alcohol research, I can attest to the fact that signiicant progress has been made. However, it could have been achieved more rapidly and more broadly if more support had been available. A greater number of talented and dedicated individuals could have been retained in this field had it not been for an uneven and sometimes unpredictable state of research support. Recent improvements in the funding for alcohol research, albeit relatively modest compared to the magnitude of the problem, have shown the feasibility of achieving significant progress through increased funding. These efforts have yielded important leads which, through appropriate support, can now be translated into findings that would meaningfully affect the health and economic status of a large segment of our population. Whereas the President's fiscal year 1988 request would in fact result in a shrinking of the presently ongoing efforts, the fiscal year 1988 professional judgment budget would allow for continuation of all significant efforts, with a modest expansion into those areas where significant breakthroughs can be anticipated but are contingent upon adequate funding.

Senator HOLLINGS. Do you get young residencies available for research in alcoholism coming out? Smart students coming out of a medical school, would they want to get into that field?

Dr. LIEBER. We do have a certain number who get into that field.

But it would be extremely important to get some stability of funding to attract more of them. What has been discouraging is the fact that, although 1 year there may be some funding available, like last year for instance, the next year there is an attempt made to cut some of that again.

And unless we give some stability to the funding process, those smart individuals may be smart enough to go to other fields. And so we have to do something to attract them, and one thing we can do is to provide them with the hope of stable support.

I would be happy to give you additional information. Certainly my written testimony has a number of other examples of breakthroughs which can be now applied to the field if sufficient support is made available.

Senator HOLLINGS. Very good, sir.

I was noticing that—we appreciate the research and the work you are doing. What other alcohol and research center do we have down in my backyard? Are there some in Georgia, some at Duke? Where? I am trying to get educated.

Dr. LIEBER. Well, in the genetic field you have Dr. Felder. Dr. Felder has developed an interesting animal model, some animals that lack one of the enzymes involved in alcohol metabolism.

Senator HOLLINGS. Where is Dr. Felder?

Dr. LIEBER. He is at your State University of South Carolina, and he has this animal model. This animal model, because it lacks one of the enzymes involved in alcohol metabolism, has provided us with a very important tool to answer the question you have raised, namely what is the chemical basis for alcoholism.

Senator HOLLINGS. We have the chairman here now, so you are going to get really cross-examined. [Laughter.]

Doctor, we appreciate it very much.

STATEMENT OF FLOYD E. BLOOM, M.D., SCRIPPS CLINIC & RESEARCH FOUNDATION

Senator CHILES [presiding]. We will hear now from Mr. Floyd E. Bloom of the Scripps Clinic & Research Foundation. Dr. Bloom.

Dr. BLOOM. Senator, thank you very much for the opportunity to speak to you.

Let me say first, on the behalf of all of us researchers, how much we appreciate the support we have received from Congress in the past and the investment you have made in alcoholism research. And I would like to spend my few moments expanding on my written testimony and tell you a couple of the reasons why you might find it in our national interest to go for the professional judgment budget for the support of NIAAA research.

I am a member of the National Academy of Sciences and I sat on the Institute of Medicine Committee that in 1981 advised Congress on the opportunities in alcoholism research. And I have had the opportunity to review the panel report that will be coming to you soon, in which the Institute of Medicine re-examined 5 years later where we have come and how many new opportunities there are at hand for us to pursue.

I think you will find that report, as well as the report that was just handed to you, the sixth annual report to Congress on alcohol and health, full of progress and full of opportunities.

My particular area of research is on the brain. My particular area of interest is in the chemical signals that one brain cell uses to communicate with another. It is that particular process that we believe is the root cause of intoxication.

And Senator Hollings was particularly interested in what might be the cause of alcoholism. The problem is not that there is one cause of alcoholism, but that there are probably many, many causes of alcoholism, and different families and different genetic backgrounds perhaps lend themselves to particular interruptions.

In my written testimony, which has already been submitted to you, I called attention to one particular example that helps to establish the kind of work that is being done on the brain today that is pertinent to alcoholism. The Senator is probably aware of a major class of tranquilizing drugs that are often called valium of librium. We call them chemically benzodiazepines.

They are one of the most widely prescribed and abused drugs in the United States. We do not look at that as a disease problem because for the most part doctors give those pills to people to calm down their heads.

One of the major problems that we have in emergency rooms is the combination of alcohol and the excess use of benzodiazepines, perhaps the major cause of drug-induced deaths that appear in our emergency rooms today.

Now, studies of the brain have revealed that the way in which benzodiazepines calm people's anxiety is very similar to the way in which alcohol reduces our awareness and our ability to focus on the world around us. And studies done with very fine microelectrodes recording the activity of single patches of electrically active points on nerve cells have shown exactly how these two classes of drugs interact with each other.

Two years ago we did not have the slightest clue as to how either alcohol or benzodiazepines produced their actions. But thanks to an extraordinary piece of research, it is now possible to say that the brain produces a natural chemical whose receptor sites produce the place in which benzodiazepine drugs can act.

And that natural benzodiazepine molecule has been purified from the brain. Its exact molecular structure and even its gene location has been determined. It has been measured in the brains and spinal fluid of human beings with and without histories of alcoholism.

And it seems to be very closely correlated with the disease of alcoholism. What is very, very surprising about this natural compound is that it produces a state of heightened anxiety.

It is as though when the brain is normally conducting its affairs it has within it a chemical that makes us anxious, and the drug, benzodiazepines, turns down that signal. Many researchers now believe that alcohol acts at a very close site to that at which this natural compound works. And one of the hypotheses to explain why some people may be alcoholic and others not would be a change in the way that gene for this particular natural brain signal is expressed and how the brain cells respond to it before and after an exposure to alcohol.

And that is just one of, I would say, dozens of examples that we might be able to provide to the Senator if there is interest of the ways in which chemical research on the brain is disclosing important new clues as to how it is that alcohol affects our brains and our behavior.

PREPARED STATEMENT

I thank you for the opportunity to appear before you, and I would be pleased to answer any questions if the time would permit.

[The statement follows:]

STATEMENT OF FLOYD E. BLOOM

Mr. Chairman: It is a pleasure to submit my written testimony for consideration by the United States House of Representatives Labor-HHS Sub-Committee on Appropriations and speak with enthusiasm for support of the research budget requested for the National Institute on Alcohol Abuse and Alcoholism in FY 1988. I speak from the perspective of an active medical researcher in the field of alcoholism, and as a Member of the Institute of Medicine Panel that reported in 1981 and 1983 on the Opportunities in Alcoholism Research, as well as being a Member of the National Academy of Sciences.

The IOM Panel Report highlighted the magnitude of the burden of alcoholism on our national economy and on the health of our citizens. At that time research on alcoholism and alcohol abuse was deemed to be grossly underfunded in relationship to these costs, and also in relationship to other areas of bio-medical research, and we provided a survey of important major opportunities that were ready for extension and scientific investigation to help find solutions to the the problems of alcoholism.

Since that time, Congress has provided a major spurt of research support funds, which have more than doubled the base level, but which still amounts to the smallest research effort of any of the categorical Disease directed Institutes in the NIH/ADAMHA agency of HHS. Although there has been a important improvement in both the quality and quantity of researchers involved in alcohol related research, largely through the National Alcohol Research Centers Program, both that program, the extramural grants program and the NIAAA Intramural Research Program still have important areas of opportunity which remain either underfunded or underutilized. Many of my fellow researchers feel that there remain important opportunities ready for further productive pursuit to the benefit of the victims of alcoholism which would warrant an important increase in the NIAAA research budget.

Many of the problems that are ripe for scientific exploitation today were barely visible when the IOM report was presented to Congress. High on the list of these important open opportunities are the strong and continuing indications that susceptibility to becoming an alcoholic can be strongly influenced by inheritable factors. Not only does alcoholism tend to run strongly within families as judged by pedigree and adoption studies. There are also indications that biochemical and electrophysiological tests may soon provide insight into tests which can predict which family members of an alcoholic may have inherited the alcoholism susceptibility. In addition, work on the toxic effects wrought by alcohol exposure by maternal consumption of alcoholic beverages during pregnancy have indicated the severity of this the only known form of preventable mental retardation.

Furthermore, recent evidence suggests ways in which it may be possible to devise drugs that can reverse the ability of alcohol to produce intoxication-- a development that has both theoretical and practical importance. This line of research is based in part on the observation that the minor tranquilizing drugs, such as valium and librium-- drugs known as "benzodiazepines"-- act in the brain at select sites, termed receptors. What has become clear in the past year, is that these sites exist in the brain because the brain normally employs as a neurotransmitter a benzodiazepine like molecule, although the naturally occurring molecule is chemically quite different. Furthermore, and importantly, while the benzodiazepine drugs act to prolong and deepen the intoxicating effects of alcohol on the brain, the natural molecule acts in the opposite manner, to arouse the brain. Further work will no doubt reveal the mechanisms of this action and determine the degree to which synthetic versions of the natural molecule can interfere with the actions of alcohol. In any case this is but one of the many exciting findings that have significantly strengthened the field of alcohol research, and served to attract new scientists to its study. As Program Committee Chairman for the Research Society on Alcoholism, we were pleased and surprised to receive a nearly 40% increase in the number of volunteer abstracts submitted for the 1987 meeting, yet another sign of the increased momentum of the field.

Knowing the severe time demands placed on the Committee's deliberations, I shall not extend my testimony. However, if there are any specific questions that I or my staff may be able to answer we should be pleased to do so. I regret that research commitments prevented me from testifying in person this year. However, in closing, let me express on the behalf of those whose lives are burdened by problems of alcoholism and alcohol abuse, and on the behalf of my fellow researchers who are trying to determine the nature of this problem and some possible preventive measures, that we appreciate the past efforts of Congress to recognize the importance and the opportunities of this field, and urge that the level of funding proposed this year receive congressional endorsement. There is little doubt in my mind that the funds will be well spent.

Senator CHILES. We thank you. And obviously there is a concern of, why can we not find out more, and if we have been in this field for a long time why do we not have some answers.

I am sure that when we think of the problem that we have here, we need to continue to look for them. And it costs us millions of dollars, alcohol and alcoholism and all of the problems that come from that.

Dr. BLOOM. Well, sir, we might just liken it to the situation with diabetes melitis, a disease that affects a very large proportion of our population and for which the cause and cure has been known for some 50 years. And that is it is a deficiency of insulin.

Insulin is sold in the drugstore and you can put the insulin back, but it does not cure diabetes, because we do not understand the root cause of the problem. Diabetes is a problem that in part we have produced on ourselves by imbibing alcoholic beverages.

But in part it is because our nervous systems vary, yours and mine. Everyone in this room has a slightly different nervous system. Some of us, our nervous system is made up of genes that cause us to be very susceptible to small amounts of alcohol and to be unable to end what might be a normal pleasant social occasion.

So the fact that we do not know exactly what causes it all the way through is only a matter of the fact that it has only been in the last decade that serious amounts of research have been invested in alcoholism, that we have been able to recruit to the field the best of our scientific personnel to be able to turn their attention to this.

And because there are only so many scientists and so many, many problems, it is always an effort for us in the field to be able to recruit the best minds to our programs. We need, as the other witnesses have said, a sign from Congress that there will be a stable and increasing budget to be able to recruit these best minds and keep them in our field and help solve those problems.

Senator CHILES. Thank you, doctor.

Dr. BLOOM. Thank you.

STATEMENT OF STEVEN W. LESLIE, PH.D., UNIVERSITY OF TEXAS COLLEGE OF PHARMACY

Senator CHILES. Now we will hear from Steven W. Leslie of the University of Texas College of Pharmacy.

Dr. LESLIE. Thank you.

I am Steven Leslie. I am professor of pharmacology at the University of Texas at Austin, and I am also the director of the Institute for Neurological Sciences at the University. We do research on brain function.

My research is similar in many respects to the research that Dr. Bloom just described. We are interested in how nerve cells communicate with other nerve cells in the brain and how alcohol affects that nerve cell communication. And I have been in this field for about 7 years, since the late 1970's.

And I am not that old of an investigator, but I have seen most of what alcohol research has to offer. And the message that I would like to give you right now is that I think that we are positioned very well to make some important discoveries in the near future.

One of the problems that we have had with studying brain function in general is we have—we just have not understood it, how is it that a nerve cell regulates itself. Well, that has not been well understood.

Recently, some important discoveries have been made and it is better understood now. There are some very significant things that we can apply alcohol research to. There are some interesting tools that have been recently discovered, that will provide interesting results. And let me just tell you about one of those drugs.

It is a drug. The name is not important, but let me give it to you anyway. It is a drug that is called RO15–4513. It is an investigational drug. This drug is interesting because it seems to reverse alcohol intoxication. Well, that kind of a drug could be interesting from a social standpoint as well as a research standpoint.

Now, one might debate whether such a drug would be worthy of putting into the public. You could talk about that in a social arena, I guess, and get a lot of questions about it. But one thing is certain. If you could find a drug—and this one may be that drug—that specifically reverses the intoxicating effects of alcohol, then you would have a drug that you could study to find out how alcohol produces intoxication.

This drug is a drug produced by Roche and there is a lot of interest in this drug, and it is producing interest not only from the alcohol research community, but from neuroscientists outside who are interested.

I think the genetic area is also very interesting. We have heard about that, the genetic link to alcoholism. With the application of molecular biology to the study of genes and how they work, to the understanding that alcohol has a genetic component, the combination of those two make it, I think, realistic in the near future that we might find a marker for alcoholism such that we would be able to tell people, are you at risk, genetic risk, or are you not when you go out to consume alcohol in the public environment.

We are positioned, I thin, very well. The budget that the President has recommended, if it is approved, I think will be a very serious setback. And the budget that is recommended by the Research Society on Alcoholism, on the other hand, I think will provide a modest growth, and it will bring new young investigators in, and I think that will be to the benefit of all of us.

Thank you very much.

Senator CHILES. When did you think that we might be able to find such a marker that you are talking about?

Dr. LESLIE. Well, that is an interesting question. If a specific gene were located or suspected, then it would take a while to purify it. Then it would take a while to develop antibodies against it. Then it would take a while to study it.

PREPARED STATEMENT

And you are probably talking about a concerted effort by a number of people over a 5- to 10-year period, I would say. But I think that is realistic.

Senator CHILES. Thank you, sir.

[The statement follows:]

STATEMENT OF STEVEN W. LESLIE

My name is Dr. Steven Leslie. I am the Sublett Professor in Pharmacology, the College of Pharmacy and Director of the Institute for Neurological Sciences Research at the University of Texas at Austin. I have devoted my research career to the study of the biochemical actions of drugs of abuse on brain function, with particular emphasis on alcohol. I currently hold a Research Scientist Development Award and a research grant from NIAAA and I serve on the Neuroscience and Behavior Subcommittee of the Alcohol Biomedical Research Review Committee of NIAAA. My interest in alcohol stems from both a scientific standpoint, because of the profound impact this drug has on our society, and from a personal family involvement with the disease of alcoholism. My father was an alcoholic who died at the age of fifty-seven from complications of chronic alcohol abuse (esophageal hemorrhage secondary to liver cirrhosis). I saw this disease destroy the life of a brilliant man. If we had the time, I could also tell you many horror stories about growing up as a son of an alcoholic. I had feelings of insecurity, confusion and guilt that no young person should have. As an adult, even though I am a scientist trained to study the actions of alcohol on the brain, I still harbor strong feelings that maybe only sons and daughters of alcoholics would understand.

It is clear to me as a result of my experiences and from my knowledge of the scientific alcohol literature that alcohol abuse and alcoholism are at the very top of the problems that we have to deal with in the United States. We are all concerned about diseases such as AIDS which may become epidemic if something is not done soon. Unfortunately, alcohol abuse and alcoholism are now at epidemic proportions. It is estimated that eighteen million adults over the age of eighteen are alcoholics or problem drinkers. In addition, an alarming number of young people under the age of eighteen have problems with alcohol. In a 1985 survey of high school seniors, more than half reported their first use of alcohol before the 10th grade. One in twenty seniors drank every day. Episodes of heavy drinking (five or more drinks at a time) during the preceding two weeks were reported by thirty-seven percent of the seniors.

Alcoholism problems cost the Nation more that $116 billion annually. These costs are distributed primarily between the cost of health care from complications of alcoholism and the cost to industry from lost employment and reduced productivity. Recent estimates indicate that alcohol abuse maybe responsible for up to fifteen percent of the Nation's health care costs. The liver is one of the organs most significantly damaged by alcohol. Cirrhosis of the liver is the 9th leading cause of death in the U.S. As was the case for my father, chronic alcohol abuse substantially reduces life-expectancy. People who died of alcoholic cirrhosis and alcohol dependence died an average of 14 to

15 years prematurely. Alcohol abuse during pregnancy is one of the leading causes of mental retardation. The incidence of fetal alcohol syndrome (FAS) is estimated at 1 to 3 per 1000 live births. More than half of all fatal traffic accidents, murders, suicides and most cases of child and spouse abuse are alcohol related. A large majority of the nation's street people are in their helpless situation because of alcoholism and drug dependence.

Even compared with other major health-related problems in the U.S. such as heart disease and cancer, alcoholism ranks as the nation's second most serious and significant disease. When alcoholism is combined with our national problem of alcohol abuse there is no health related problem which has a comparable impact; a staggering figure is that one in every five Americans is adversely affected by alcohol abuse and/or alcoholism. Our nation is now caught in a situation where we are beginning to realize the seriousness of alcohol and other drug abuse problems. We recognize that something needs to be done. Public education about the serious nature of driving under the influence of alcohol and the legal crack-downs has helped to bring attention to the alcohol abuse and alcoholism problem. However, this is only the beginning. We need more. The full spectrum of the problem needs to be recognized and translated into a long-term, organized effort to get at the bottom of the problem.

The bottom of the problem will be reached when we understand how alcohol acts on the brain to change its function. This will be accomplished through a commitment to a long-term, organized research effort. The level of research support is of key importance. The NIAAA research budget has always been extremely low in relation to the significance of the disease and in comparison with the research budgets of other NIH institutes. The NIAAA research budget for FY 1987 is only 6% of that allocated for cancer research and 9% of that allocated for heart, lung and blood disorders. Interestingly, the NIAAA research budget is less than that allocated for dental research. There are probably several reasons why funding for alcohol research has been so paltry over the years. Primary among these reasons is the familiarity of the public with alcohol and the perceived benign effects of this social drug, the stigma associated with the disease of alcoholism and, until recently, a lack of understanding about how pervasive our national problems are with alcoholism and alcohol abuse. The underfunding of alcohol research, in relation to the magnitude of the alcohol problems and the research opportunities that exist, is widely recognized. In 1984, the Institute of Medicine recommended that the research and research training budget of the NIAAA be increased to $100 million in constant 1983 dollars. Modest progress has been made in increasing the alcohol research budget over the past several years. The number of grants has increased from 69 in 1983 to 100 in 1986 and an estimated 111 in 1987.

The President's FY 1988 NIAAA budget proposal of $81,717,000 would provide only 89 new and competing project grants and represents a severe setback in the goal of steady progress towards a more reasonable level of funding. The alternative proposal supported by the Research Society on Alcoholism requesting a total budget of $111,429,000 represents a request for modest growth and among other things has the following benefits: It provides 1) a 20 percent increase in the number of research project grants which will attract additional scientists into the alcohol research field, 2) full funding and expansion of existing research centers and the award of one new center focused in alcohol and aging, 3) expansion of the Research Scientist Development Award program to attract young scientist with a high level of research potential into the alcohol field, 4) provide $4.8 million for AIDS-related research to study the effect of alcohol in immunocompetency and the functioning of T- and b-lymphocytes, 5) support for 203 research trainees, a necessary step to assure the future availability of well-trained men and women upon whom the nation depends for the success of the alcohol research. The President's budget would maintain the number of research trainees at 125, 3 more than FY 1987, thereby rejecting a National Academy of Sciences recommendation for 1,800 trainees for ADAMHA. The President's budget would also require 5 percent cuts in the average costs of all the research centers and regular research grants, contracting the scope of science that could be undertaken.

With adequate funding, the research supported by NIAAA will help in many important ways. These include 1) the identification of physiological and biochemical markers of genetic susceptibility to alcoholism to help identify individuals at risk, 2) development of an objective marker of alcohol consumption to assist the physician in diagnosing alcohol-related disorders, 3) development of ways of ameliorating the damaging effects of alcohol on the fetus, 4) development of improved pharmacological agents for the treatment of alcoholism and alcohol withdrawal, 5) clarification of the impact of alcohol use during adolescence on physical and psychological maturation, 6) the obtaining of a better understanding of the environmental and behavioral determinants of alcohol consumption, 7) development of better methods of evaluating the effectiveness of intervention approaches aimed at preventing alcohol-related problems, 8) gaining a better understanding of the impact of alcohol on the immune system and its role as a possible co-factor in the transmission and progression of AIDS, and 9) obtaining a clearer understanding, through expanded application of nuclear magnetic resonance (NMR) and other imaging techniques, of the relationship between alcohol abuse and brain pathology.

There are several areas of alcohol research that I think hold particular promise. In the way of predicting which individuals might be at high risk for developing alcoholism, the discovery that there may be a genetic component to the disease of alcoholism and that we may be able to find a biological marker for the disease is very important. The discovery of such a marker would allow us to reliably predict which individuals would be at high risk for developing alcoholism and would serve as a definite warning system for these individuals **before** they have an alcohol problem. The establishment of the observation that offspring and relatives of alcoholics are at higher risk for developing alcoholism has already helped to focus attention, in a much less defined way, on individuals at risk. In the way of discovering how alcohol works in the brain, we now know that its principal action is at the junction between one nerve and another. Important recent discoveries have been and are being made concerning how alcohol alters communication between one nerve cell and another by acting at this junction. A complete description of this area of research would be far to lengthy to include in this document. However, a particularly exciting recent finding is that an experimental drug, RO 15-4513, is capable of reversing the intoxicating effects of alcohol without reducing blood alcohol levels. This drug may or may not become clinically important in the treatment of alcohol related problems. It will most certainly, however, be of tremendous value experimentally in studying how alcohol produces intoxication. It has been shown already that this drug may reverse alcohol intoxication, at least in part, by reversing alcohol' s actions on chloride ion conductance in nerve cells. Chloride conductance is known to be important in reducing the excitatory activity of nerve cells. Alcohol facilitates this process and RO 15-4513 reverses alcohol's effects.

We are at an exciting point in the alcohol research field. Recent pioneering discoveries have caught the attention of the scientific community. Even those scientists who are not yet involved in alcohol research are watching. The promise is excellent for future scientific solutions to our questions about how alcohol intoxication and addiction occur. We must, however, maintain a consistent momentum. The President's proposed FY 1988 NIAAA research budget would result in a significant setback. The alternative budget supported by the Research Society on Alcoholism, on the other hand, would maintain a level of support that is essential for forward momentum in alcohol research.

STATEMENT OF HERMAN H. SAMSON, PH.D., DIRECTOR, ALCOHOLISM AND DRUG ABUSE INSTITUTE

Senator CHILES. We will now hear from Mr. Herman H. Samson, the director of Alcoholism and Drug Abuse Institute.

Dr. SAMSON. Thank you, Senator Chiles. I appreciate the opportunity to talk to the committee.

I am Herman Samson. I am director of the Alcoholism and Drug Abuse Institute of the Warren G. Magnuson Health Sciences Center at the University of Washington in Seattle. This research institute is somewhat unique in that it is supported by both State and Federal dollars. We have a wide range of research that goes on there, and we are trying to do multidisciplinary approaches to the studies and problems of alcoholism.

One of the things of which I have been predominantly involved in in the last few years is to try to look at some of the more behavioral approaches that interact with the generic effects that we have heard about so far. These approaches have led to the demonstration that in fact we can change preferences for taste for alcohol and a variety of other things through a variety of different behavioral techniques.

These techniques may be very critical in the way in which alcohol is initiated, in terms of the way in which people become initiated to drink alcohol. We are now trying to look at these processes in early initiation with humans to get a better idea about prevention programs in youth that might be more applicable to try to alter the onset of drinking in youth, which would lead to their gateway drug use.

I want to take and stress that I, too, feel that we are poised at this point in time for the development of the field because of the base knowledge that has been laid down in the basic neurosciences and in the biological and psychological sciences over the last 5 to 10 years.

The field is not really that old. We have only been going maybe 25 or 30 years to really look at this problem in a real scientific way.

The coupled work that is going on in the neurosciences at this time strongly gives us the capability now to apply these techniques. But we must recruit the researchers that know how to use these techniques to the questions involved with alcoholism.

And as you have heard already by other speakers, this is not always easy to do if they are not guaranteed of some kind of continued funding. A young researcher trying to get started in the field, looking at a career, is going to question whether or not he is going to be able to start in this field and go anywhere if he cannot get the continued funding.

I speak from some experience there, having had the opportunity to be a career development scientist with the National Institute of Alcoholism and Alcohol Abuse, which provided me with 5 years of continued funding to really support and get going this kind of research.

Therefore, I would strongly urge the committee to consider the professional budget recommendation as a level to not only enhance research, but to bring researchers into the field and help us alleviate the critical problems that we now have, that is probably, if not No. 3 as said everywhere, may be the No. 1 health problem in the United States.

Thank you.

Senator CHILES. Thank you, sir.

[The statement follows:]

STATEMENT OF HERMAN H. SAMSON

Thank you for letting me speak to you today about the need for increased funding for research into the problems of alcohol abuse and alcoholism. I come not only as a researcher who has been actively involved in this area for more than 25 years, but also as someone who has experienced the effects of alcoholism within my family, an experience shared by many Americans given the prevalence of alcohol problems in our society.

I began my research into the effects of drugs and alcohol on the brain in 1963 during my graduate training and have worked in the area ever since. My research has had several focuses as a result of a broad interest in many aspects of the problems of alcoholism. In addition to my academic positions, I have held a Career Scientist Development Award from the National Institute on Alcohol Abuse and Alcoholism. My current position is Director of the Alcoholism and Drug Abuse Institute at the Warren G. Magnuson Health Sciences Center of the University of Washington. This is a multidisciplinary research institute, which receives both state and federal support. The nature of the research conducted under the auspices of the Institute ranges from basic science studies into the cellular effects of drugs and alcohol to policy research concerning such topics as DWI recidivism and the prevention of AIDS in IV drug abusers.

I have been a member of the Research Society on Alcoholism since the mid 1970s. Members of this society are prominent scientists in the United States who are applying modern research knowledge and techniques to our search for further understanding of the problems of alcoholism and alcohol abuse.

As a function of both my current position and my experience in the field, I have been involved in numerous research projects concerning a wide range of alcohol-related problems. It has become clear to me that over the last 20 years the results of intense research efforts by dedicated scientists are beginning to provide the critical foundation of knowledge upon which effective understanding and treatment of alcohol addiction can be achieved. However, as in any medical research field, the study of alcoholism has not and most likely will not provide simple, quick answers--answers we would all like to have given the pressing problems created by alcohol use and abuse. However, because of research carried out in the last few years, a much better appreciation of the complexity of alcohol abuse is now coming into focus and exciting new avenues of important research have opened.

One such area in which I have had personal experience is the effects of alcohol upon the fetus. From the pioneering work done at the University of Washington in the 1970s by Drs. Kenneth Jones and David Smith, we now know that maternal drinking at any stage of pregnancy can adversely affect the unborn child's development. It has recently been estimated that maternal drinking is the number one cause of birth-related defects in the United States, surpassing Down's Syndrome. From biological models we have amassed considerable evidence that alcohol has a multitude of effects upon critical developmental processes. The number of children born with disabilities could be greatly reduced if we found effective ways to eliminate maternal alcohol abuse and alcoholism. One way to assist the physician in treating alcohol abuse is to have better indicators capable of detecting alcohol usage. Recent research on a variety of biochemical procedures holds promise for better, quantifiable tests of recent drinking history. If such tests were available, the physician could screen pregnant women for potential alcohol abuse which might otherwise go undetected. Upon detection, appropriate treatment to reduce the mother's drinking could prevent many of the damaging effects alcohol has on the unborn child.

Another example of the converging aspects of alcohol research concerns our rapidly expanding knowledge of genetic factors in the development of alcoholism. A variety of genetic components, including certain personality traits, contribute in different ways to the risk of adult expression of alcohol-related problems. Some of these genetic factors are apparently exhibited differently in men and women. Research also indicates that environmental factors, both alone and in combination with genetic risk, can increase the probability of developing alcohol dependency. However, we still do not understand how these environmental factors may relate to relapse following treatment, nor do we understand how genetic factors may be related to relapse problems. While much promising work has been started in these areas, more is urgently needed.

I would like to stress that there has been important progress in the field in the last 20 years. But given the enormity of the problems alcohol creates for this society, the rate of progress and the number of capable, creative researchers are not satisfactory. Alcoholism and alcohol-related problems may well be the number one health problem in the United States. Drunk driving is clearly the number one killer of young people under the age of 25. Alcohol may be the underlying cause of more than 60% of the illnesses treated in our public assistance hospitals. Alcohol's effects on immune functioning are just starting to be understood, and if what has been suggested from the data so far is substantiated, alcohol could be one of the major associative factors for the actions of carcinogens. The effects of heavy drinking on cardiovascular disease and stroke are well documented but the mechanism by which this damage occurs remains to be clarified. The effects of alcohol on the liver appear to be related not only to the amount of alcohol consumed but to some genetic component as well. Answers to these issues could save millions of dollars and prevent the needless deaths of thousands.

It is critical that we continue with added effort to build on the solid research base created over the last few years, not only to alleviate individual suffering but to reduce the enormous economic burdens which alcohol-related problems create for the American people. However, this can only be done with increased support for the National Institute on Alcohol Abuse and Alcoholism. I strongly urge you to consider the Professional Judgement Budget as an appropriate level of funding for NIAAA given the critical need for research at this time. This proposal requests $29.7 million over the President's request and $14.4 million over the the current 1988 services level.

One major effect of this Professional Judgement Budget request would be to increase by 20% the number of research projects which NIAAA could support. This would include awarding many new grants in the areas of identified high priority, including the development of a gene bank for the study of biological susceptibility to alcoholism. Funding at this level would also provide for increased intramural research and for the badly needed training of new scientists. It would expand the Research Career Scientist Awards, which attract top investigators to the alcohol field. This budget would also provide $4.8 million to examine the effects of alcohol on the immune system in relation to the development of AIDS. It would provide for additional clinical training in our medical schools, which are in great need of enhanced training in the pervasive effects of alcohol on health.

There are many additional NIAAA programs which would benefit from this level of funding. The important point, however, is that with this funding commitment, research in alcohol abuse and alcoholism will be able to continue advancing at a rate which will allow solutions to some of the above mentioned problems to become a reality -- not merely a dream for the future.

STATEMENT OF JOHN C. CRABBE, JR., PH.D., OREGON HEALTH SCIENCES, UNIVERSITY SCHOOL OF MEDICINE

Senator CHILES. Now we will hear from Mr. John C. Crabbe, Oregon Health Institute, University School of Medicine.

Dr. CRABBE. Thank you, Senator Chiles.

My name is John Crabbe. I am professor of medical psychology and pharmacology at the Oregon Health Sciences University and at the VA Medical Center on Portland, OR. I have been actively engaged in research since 1968 and have been doing alcohol research full time since 1976.

And I have made the rather long trip from Oregon here today because I think it is vitally important that your subcommittee continue its efforts on behalf of providing the funding that you have been so generous in working for in the past, and specifically to support research on the biological basis of alcoholism.

My area of research specialization is behavioral genetics, and I believe strongly that it is critical for us to support basic research that is designed to identify individuals who specifically are at genetic risk for developing alcoholism.

These questions are extraordinarily difficult to address in humans. Consequently, many research investigators interested in the genetic basis of alcoholism, including myself, have concentrated on genetic animal models of alcoholism, using specifically developed lines of rats and mice.

From my own specific research, I can offer you the example of some recent studies that we have been doing with lines of mice that we have developed that differ in genetic susceptibility to the severity of withdrawal from alcoholism.

Looking at these mice, we have identified two specific genes that appear to be differentiated in these lines that are related to traits related to alcoholism in mice. And this offers us the opportunity to continue to study these and perhaps develop the kind of genetic markers that we are looking for in humans, at least at the level of mice.

I think it is critically important to continue to try to develop these genetic markers, because the Institute of Medicine report in 1983 indicated that there were 28 million children of alcoholics in this country, and we need to know which of those are truly at increased risk.

I think there are three specific practical outcomes of supporting basic research with animal genetic models: First, we will increase our knowledge of the basic mechanisms of action of alcohol. We need this knowledge as a basis for the rational design of any kind of a specific therapy for alcoholism.

Second, if we were able to identify that subpopulation of individuals that is truly at genetic risk, the benefit to the prevention and therapy costs would be dramatic, obviously.

And third, I think we will be able to in humans identify the specific genes that exert important controls on how alcohol produces its effects on the central nervous system, and this is the first step, the necessary first step, to understanding how the genetic predisposition toward alcoholism gets translated into the consequences of the disorder.

Progress in this area, as you have been hearing, has been limited by the unavailability of funds. The National Institute on Alcohol Abuse and Alcoholism has been inadequately funded since its inception. The President's proposed fiscal year 1988 budget is a step backward, rather than a step forward.

As a member of the Research Society on Alcoholism, I urge you to support the professional judgment budget that we are offering. This modest increase in support for basic research grants and for training stipends for young scientists is what we need to continue to bring new investigators into the field.

Thank you for the opportunity to testify.

PREPARED STATEMENT

Senator CHILES. Thank you, sir.

As you know, Senator Hatfield is a very valuable member of this subcommittee and has been chairman of the full committee, and he expressed an interest in your appearance today. And I thank you for your testimony.

Dr. CRABBE. Thank you.

[The statement follows:]

STATEMENT OF JOHN C. CRABBE, JR.

I am an Associate Research Career Scientist employed as a Research Geneticist at the Veterans Administration Medical Center, Portland, Oregon. My academic affiliation is with the School of Medicine of the Oregon Health Sciences University where I am Professor of Medical Psychology and Pharmacology. I have been actively engaged in research since 1968, and my entire effort has been directed toward the study of the biological bases of alcoholism since 1976. I have been a member of the Research Society on Alcoholism since 1979, and have served on its Elections Committee since 1982. The goals of the Society are to support and promote the highest quality research on the causes of and effective treatment for alcoholism, to foster the development of programs for training researchers in the alcoholism area, and to provide leadership and coordination among other local, national, and international groups providing research funding devoted to alcoholism. I have made the rather long trip from Oregon here today because I believe that it is vitally important to the future health of this country for our government to support research on the biological basis of alcoholism. In my testimony, I will try to explain my reasons for this strongly-held belief, and indicate where I believe such support should be directed.

My area of research specialization is behavioral genetics. We have known now for many years that a susceptibility to develop alcoholism is inherited. Studies in the 1960s and 1970s clearly indicated that the first-degree relatives of an alcoholic are at much higher risk for alcoholism, regardless of whether or not they were reared in a home with that alcoholic relative present. This is persuasive evidence that some biological risk factor is inherited. At this time, we still have no idea what exactly is inherited that causes this increased risk. Clearly, not all first-degree relatives of alcoholics become alcoholics. I believe strongly that it is critical for us to develop the capacity to determine an individual's actual risk of developing alcoholism.

These questions are extraordinarily difficult, time-consuming, and expensive to address in humans. Partly for this reason, many research investigators in the alcoholism field have concentrated on the development and study of animal genetic models. The ultimate goal of much of this research is to identify specific behavioral or biochemical traits in these genetically specified lines of mice and rats that could serve as markers to predict an individual animal's genetic predisposition to alcohol. Our work has largely concentrated on developing, through genetic selection, lines of mice that wre susceptible or resistant to different effects of alcohol. These mice serve as animal genetic models of alcoholism. Through studying these mice, we have discovered that a genetic predisposition to alcohol withdrawal is unrelated to initial sensitivity to alcohol. If we could extrapolate this to human terms, we would expect to find that an individuals predisposed to become alcoholics do not differ from normal individuals in how they initally respond to alcohol. On the other hand, we have found that mice genetically predisposed to become physically dependent on alcohol are much less sensitive to the effect of alcohol to inhibit seizures. This finding might ultimately lead to a test capable of diagnosing an individual human's genetic predisposition to alcohol dependence. Finally, we have identified two specific genes by studying specific strains of mice. One of these genes seems to influence the severity of alcohol withdrawal, while the other controls the preference for drinking solutions in different mouse strains.

There are two reasons for the need to identify clear markers of genetic risk. First, on the grounds of simple compassion, all of us in the health professions want to reverse the trend that shows increasing numbers of adults and, most frighteningly, adolescents suffering from the devastating consequences of alcoholism. Second, the economic impact of alcohol-related problems is enormous. According to the Institute of Medicine's figures for 1983, 15 percent of all hospital costs were alcohol related, and the total economic impact of alcohol-related problems was $117 billion. There were an estimated 10.6 million alcoholics over the age of 18, and an additional 7.3 million individuals drinking abusively. The number of adolescents with problem drinking was estimated to be 4.6 million. Most relevant to the question of genetic risk is the fact that there were 28 million children of alcoholics in 1983. How many of these children will contribute to these appalling statistics in 1993?

Simply stated, the problem is that one does not inherit "risk," one inherits genes. Advances in molecular biology and genetics in the last decade prove unequivocally that there fundamental biological determinants of alcoholism awaiting discovery. What we now need is the financial support to mount research designed to discover how many genes, and which genes determine the risk for alcoholism. Only then can we begin to attack the foundations of the aberrant biology of alcoholism.

It is frightening how little we know about alcohol and its effects. Basic pharmacological research into the mechanisms of action of this drug is far less developed than for most other therapeutic drugs and drugs of abuse. Similar holes riddle our picture of the biochemistry, endocrinology, pathology, and psychopharmacology of alcohol. While high-quality research on all aspects of alcohol is needed, I wish to identify one area that I believe critically in need of support today.

We need to understand the way in which genes predispose to alcoholism. One of the most efficient methods to attack this general problem right now is to focus on the development and study of animal genetic models. A number of lines of mice and rats have been produced in recent years that have highly specific, genetically determined responses to alcohol. The development of these lines is facilitated by the explosion of knowledge about the genes of rats and mice. As a consequence of the elegant and sophisticated tools offered researchers by modern molecular biological and recombinant DNA-based techniques, investigators in every biomedical discipline are incorporating genetic studies into their research. The rapid accumulation of knowledge about the basic genetics of mouse and rat offers us a potent opportunity to advance our understanding of alcohol's genetic basis in particular.

Several specific practical outcomes of supporting this line of research can be described. 1. We will increase our knowledge of the basic mechanisms of action of alcohol. This in turn will lead to a better understanding of how alcohol sensitivity, tolerance, and dependence are functionally related. The rational design of specific therapies for alcoholism will depend upon a clear understanding of the biological basis for alcohol's actions. 2. By identifying individuals truly at increased genetic risk for alcoholism we will be able to target our efforts at prevention. This, more than anything, will lead to the greatest advances in solving the biomedical problem of alcoholism. 3. By promoting research with animal genetic models, we will be able to identify specific genes that exerts important controls on alcohol's biological effects. This is the necessary first step toward specific genetic therapies designed to overcome genetic predispositions to develop alcoholism.

Progress in this area has been limited by the extreme unavailability of funds. The National Institute on Alcohol Abuse and Alcoholism has struggled with inadequate funding since its establishment. There are very few alternative resources for alcoholism research funding, and most of these are small local granting agencies that offer $10-15,000 for one-year periods. We will not be able to cure a nationwide $117 billion per year problem by relying upon municipalities to administer scattered $10,000 treatments. The development of sophisticated animal genetic models, and the intensive study of those few already available, requires substantial support. Genetic studies in particular are conducted over long time-scales, and are relatively expensive to conduct. However, the potential payoff is immense. An instructive example is the recent advance in our understanding of Huntington's Chorea that is developing in the wake of identification of the particular gene responsible. The possibility of making such progress in understanding which genes on which chromosomes determine genetic risk for alcoholism can be greatly fostered by supporting research with animal genetic models.

The president's proposed FY88 budget for NIAAA is clearly insufficient. His proposal would decrease funding for alcohol research; progress toward the goals I have described demands, rather, a substantial increase in funding. As a member of the RSA, I strongly urge the Congress to support the professional judgment budget we have offered. This proposal will increase total support of the NIAAA to $111.4 million. One critical feature of this increase would be the ability to fund an additional 130 new and competing research grants targeted for high-priority areas including the sort of genetic studies with animal models I have described. A second feature is that $4.4 million would be made available to support 203 research trainees. The capacity for sustaining the growth of the next generation of scientists who will devote their research careers to the study of alcoholism is vital to successfully traversing the road to prevention of and a cure for alcoholism. In my view, these two areas are the most critical needing increased budgetary support, for investigator-initiated research is the essential ingredient in making progress toward solving the problems of alcoholism.

Thanks you for the opportunity to testify.

STATEMENT OF ROBERT J. SOKOL, M.D., DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, HUTZEL HOSPITAL, DETROIT, MI

Senator CHILES. Now Dr. Robert J. Sokol of the Department of Obstetrics and Gynecology at the Hutzel Hospital in Detroit. Dr. Sokol.

Dr. SOKOL. I am Bob Sokol. I am professor and chairman of the Department of Obstetrics and Gynecology at Wayne State in magnificent downtown Detroit, MI, and I am also chief of the Department of Ob at Hutzel Hospital.

That is one of the largest tertiary level services, ob services, in the country, and we take care of a very disadvantaged inner city population with a high rate—these are pregnant women—of alcohol abuse, abusive drinking, and a lot of infant damage.

As a member of the Research Society on Alcoholism, I am here to testify in support of the professional judgment budget for alcohol research. Alcohol research as a discipline is very young. Fetal alcohol research is even younger. It really was first described in the modern literature in 1973,

So there is 14 years of research. There have been about 3,000 papers. And you say, my God, 3,000 papers, that sounds like a hell of a lot of research. Well, it is a tiny amount of research. Look at cancer and heart disease. This is a small, small area, but a big problem.

How do I know it is a big problem? Well, we recently did a study. We looked at all of the papers that have been published in the entire world literature, which allowed us to get an estimate of how frequently the full fetal alcohol syndrome occurs.

We looked at over 90,000 pregnancies. The rate is about 1.9 per thousand. It is higher in the United States than elsewhere in the world, about 2.2 here. It is a bigger problem in lower than higher socioeconomic status groups.

That makes fetal alcohol syndrome the most common known cause of mental retardation. It is more common, for instance, than Down's Syndrome. This is not a small problem.

Now, I said we calculated about, just taking into account the big expenses, about what it costs, and it is one-third of $1 billion a year. I look at that and I say, my God, that is a lot of money. I have heard figures thrown around in here today; it does not sound like a lot of money.

The big problem is the human suffering, though. It is indeed a big cause of mental retardation. We estimated that over one-tenth of all the people in the residential treatment centers for mental retardation in the United States are there because of prenatal alcohol exposure.

If you took all the money that we put in as a country through the Federal budget into NIAAA in support of alcohol-related birth defect research, and you take a look at the cost of a single year of treatment for this problem, you could support this type of research for a century for 1 year of support. It is about like the situation was with polio in the fifties.

We have actually learned a great deal in the 14 years. Most of the simple questions have indeed been answered. It is the complicated ones, the ones about how to really prevent this problem, that we do not have the answers to yet but I think that we do have a good shot at finding out.

About 70 percent of American women drink. I think it is very unlikely that we are going to be able to eliminate that exposure. If you are dealing with a thalidomide, a prescription drug, it is easy to stop the exposure. We cannot stop the exposure.

We are going to have to know more. We are going to have to understand the mechanism. We are going to have to be a lot more clever, I think.

What are the best buys? Well, it is tough to say. I would agree with other speakers who have said we really do need some basic animal research. We are starting. We see in our own laboratory good evidence for susceptibility, for vulnerability to this particular prenatal insult. We need to know more about that.

You do not know who to focus prevention efforts on right now. We also need clinical research as well. If you tell a woman that she is going to damage her baby if she does not stop drinking, do you know what happens? Oh my God, I am just so upset, I better go have a drink.

That is not a joke. We have done two studies, including one that was published last week, which show that is exactly what happens. We do not know how to apply, even in the psychosocial area, yet the information on how to decrease this risk for birth damage and how to improve pregnancy outcomes.

PREPARED STATEMENT

I think that this is a significantly underfunded area.

And I would like to thank you very much for listening to me.

Senator CHILES. Thank you, sir. We appreciate your being here.

[The statement follows:]

STATEMENT OF ROBERT J. SOKOL

ABSTRACT AND INTRODUCTION: Fetal Alcohol Syndrome (FAS) and alcohol-related birth defects (ARBD) are certainly not new problems, though modern recognition did not occur until 1973 (1). During the ensuing 14 years, there have have been well over 3,000 scientific publications involving the reproductive impact of alcohol (2). With so much work already performed and reported, one might expect to have in hand all or, at least, most of the "answers" to the alcohol-in-pregnancy problem. It must be remembered, however, that this is, in fact, a very young research area and much remains unknown and to be done. ARBD represent a major and extremely expensive national public health problem. The extent of this problem is such that a considerable increment in support for relevant research would be a sound investment -- it would be cost effective if only a small portion of the expensive ongoing treatment for alcohol-damaged offspring could be reduced. Promising research opportunities exist which can be expected to increase our understanding of alcohol teratogenicity and to support the development of effective early identification and prevention strategies.

ALCOHOL-RELATED BIRTH DEFECTS -- A MAJOR PUBLIC HEALTH PROBLEM: Estimating the societal cost of FAS has been shackled by the lack of a firm estimate of the incidence of this syndrome. We have recently reviewed the literature for all papers in which FAS was definitively diagnosed and in which the size of the population from which the cases came could be discerned. There were 19 such papers, reporting 164 FAS cases from populations totalling 88,236,493 live births (3) The worldwide incidence of FAS is 1.9 per thousand. The reported incidence is higher in the United States than in Europe and in lower vs upper socioeconomic status groups.

If the conservative estimate of 1.9 cases of FAS per 1000 births is adopted and only costs for ongoing care of the most clearly defined FAS-related adverse pregnancy outcomes are calculated, exclusive of more poorly defined costs of lowered productivity, disruption of personal and familial lives, ARBD other than FAS (which occur much more frequently than full FAS) and neurobehavioral dysfunction less severe than mental retardation, it turns out that -- 1) Treating FAS costs the nation nearly a third of a billion dollars per year ($321 million). 2) FAS-related mental retardation accounts for more than a tenth (10.6%) of the total cost for residential treatment of mental retardation in the United States. This is more than the costs for Down Syndrome or cerebral palsy. 3) Similar to the situation for poliomyelitis in the 1950's and given current levels of federal support for FAS-related research, FAS research could be supported for an entire century for the cost of a single year of treatment.

Additional considerations about the major public health issue of ARBD include the following: 1) Up to 5% of all congenital anomalies may be alcohol-related (4). 2) Alcohol dependence and abuse are persistent problems which are minimally responsive to public education efforts. There is no evidence that drinking, particularly at abusive levels by women, has decreased. About 60% of American women are not abstinent and at least 3-4% drink at abusive levels (5). There is no evidence that since the recognition of FAS, the incidence of this problem has decreased. Nonetheless, ARBD are potentially preventable. Their occurrence is dependent on a maternal behavior and, therefore, they constitute an avoidable risk. Research which may lead to improved methods of preventing ARBD can be expected to be highly cost-effective.

RESEARCH OPPORTUNITIES: Though FAS and ARBD are potentially preventable, we do not as yet know how to prevent or ameliorate the adverse impact of alcohol on pregnancy outcome. The road to prevention will have to be paved with research results. Studies of high scientific and technical merit will need to come from the constituency of scientists already working in this area and, perhaps, more importantly, from scientists who can be attracted to this area through the leadership of the Congress and NIAAA. It is probably fair to state that the simple questions with regard to FAS and ARBD have now been answered, but a multitude of more complex and sophisticated questions remain at all levels of inquiry. Certainly, alcohol has been well established as a teratogen. If we were dealing with any other substance, it would be relatively simple to eliminate it as a maternal exposure. This is not possible with alcohol. Thus, other approaches are necessary. To mount effective and focussed prevention efforts, we will need to understand much more about the mechanisms of alcohol's teratogenicity and the variables affecting it. It is likely that much of this new knowledge will be derived from studies in animal models. In addition, studies in human populations and in clinical samples focussing on early identification and prevention will have to be performed. What should the research agenda include? Where are the best research opportunities? What are some of the "best buys?"

1. "The risk" must be much better characterized. a) High doses of alcohol and their impact on perinatal outcome have been relatively well studied. We must now focus on moderate and low doses. b) A clear definition of the critical periods of prenatal alcohol exposure for the development of a broad range of

adverse outcomes has been elusive and requires additional study. c) If there are thresholds for specific alcohol-related adverse outcomes, these need to be defined to answer what is, perhaps, the most commonly asked clinical question, "How much is too much?" or, conversely, "Is there a safe level of drinking?" d) A dose-response curve is needed defining overall alcohol fetotoxicity and teratogenicity. It should be based, for each adverse outcome, on the lowest dose at which a significant increase in risk is detected, i.e., at the threshold for that particular effect, should it exist.

2. To accomplish the preceding objectives, it will be necessary to focus on specific adverse outcomes. For surviving offspring, the impact of prenatal alcohol exposure on the central nervous system is the most devastating (6). Based on current evidence, it appears that among outcomes less severe than mental retardation, the major impact of prenatal alcohol exposure is in the areas of attention deficit disorder and possibly decreased cognitive ability and sensory abnormalities (7-9).
3. Available study techniques which might, with benefit, be applied include electroencephalography in the human neonate and infant, as well as brain stem evoked response. In animal models, electrophysiologic studies at the cellular level can be considered. Nuclear magnetic resonance and positron emission tomographic studies, though used in adult alcohol studies, have yet to be applied in fetal alcohol studies.
4. There is now considerable evidence that host factors may influence the expression of ARBD (10). In other words, there are probably factors which increase and other factors which decrease the risk for these abnormalities. a) Defining specific maternal characteristics which are clinically detectable prior to, or at the very least, early in pregnancy might well provide a key to focussed prevention efforts. b) The concept of susceptibility/vulnerability suggests the need for investigations of interactions between alcohol and other factors, eg, other drugs, measures of nutrition at the tissue level and factors which influence placental nutrient transport, as well as alcohol metabolism. c) Investigations of any genetic contribution to ARBD, of prenatal alcohol exposure as a risk for the development of alcohol problems in the adult and regarding any paternal contribution to ARBD are needed. d) Gene probes are now available for isoenzymes of alcohol dehydrogenase and acetaldehyde dehydrogenase, as well as for enzymes and other proteins in the central nervous system (11). Molecular biologic methods could contribute to understanding susceptibility to ARBD.

6. Some recent provocative work suggests that aspirin may decrease alcohol teratogenicity in a mouse model (12). What is exciting is that this is one of few known examples in which teratogenicity of an agent may be reduced by another exogenous, rather than endogenous, factor. Further work to define mechanisms for this effect and to explore whether behavioral teratologic impact of alcohol can also be reduced is needed.

7. Alcohol and alcoholism are not going to disappear, so ARBD will continue to be a major societal problem. Further studies in focussed secondary prevention are needed. a) Among native Americans, FAS is believed to occur in epidemic proportions (e.g., 13). Research in culture specific intervention and prevention is needed. Similarly, though further confirmatory studies are necessary, pregnancies of low socioeconomic status Black women may demonstrate increased susceptibility to ARBD. Subculture specific interventions are probably needed for this population, as well. b) Currently, the most promising prevention strategies appear to involve professional education and intervention in the physician's office/clinic (e.g., 14). Further studies here should focus on improved early identification methods, not only in the areas of clinical history taking and the use of formal questionnaires, but also on the use of biochemical parameters, very probably in conjunction with, historical information.

CONCLUSION: Alcohol-related birth defect research is in its adolescence and has yet to reach its full potential. There are major research opportunities in this area. Further studies may contribute, not only to our understanding of alcohol teratogenicity, but also to understanding normal embryonic and fetal development, as well as teratogenicity in general. It is reasonable to suggest that in the future, we will be able to look back at the cost of alcohol-related birth defects, both in terms of loss of human potential and actual dollars spent for treatment, and be able to make the judgment, that, as with poliomyelitis, investment in research leading to prevention, was a "bargain."

REFERENCES

1. Jones KL and Smith DW: Recognition of the fetal alcohol syndrome in early infancy. Lancet 2:999-1001, 1978

2. Abel EL: Fetal Alcohol Exposure and Effects: A Comprehensive Bibliography. Greenwood Press, Westport, Connecticut, 1985

3. Abel EL and Sokol RJ: Incidence of fetal alcohol syndrome and economic impact of FAS-related mental retardation. Drug Alc Dependence 19:51-70, 1987

4. Sokol RJ: Alcohol and abnormal outcomes of pregnancy. Can Med Assoc J 125:143-148, 1981

5. NIAAA, Secretary of Health, Education and Welfare, ed. Alcohol and Health, 3rd Special Report to the U.S. Congress, U.S. Department of Health, Education and Welfare, Washington, DC, 1978

6. Clarren SK and Smith DW: The fetal alcohol syndrome: A review of the world literature. New Engl J Med 298:1063-1067, 1978

7. Shaywitz SE, Cohen DJ and Shaywitz BA: Behavior and learning deficits in children of normal intelligence born to alcoholic mothers. J Pediatr 96:978-982, 1980

8. Church MW and Gerkin KP: Hearing disorders in children with fetal alcohol syndrome: Findings from case reports. New Engl J Med, In press, 1986

9. Streissguth AP, Martin DC, Barr HM, Sandman BM, Kirchner GI and Darby BL: Intrauterine alcohol exposure and attentional decrements in 4-year old children. Alc: Clin Exp Res 7:122, 1983

10. Sokol RJ, Ager J, Martier S, Debanne S, Ernhart C, Kuzma J, Miller SI: Significant determinants of susceptibility to alcohol teratogenicity. In "Mental Retardation: Research Education and Technology Transfer," edited by Henryk M. Wisniewski and Donald A. Snider, Annals NY Acad Sci 477:87-102, 1987

11. Smith M: Genetics of human alcohol and aldehyde dehydrogenases. Chapter 5 in Advances in Human Genetics, Vol. 15, pp.249-290, 1986

12. Randall CL and Anton RF: Aspirin reduces alcohol-induced prenatal mortality and malformations in mice. Alc: Clin Exp Res 8:513-515, 1984

13. May PA and Hymbaugh K: A pilot project on fetal alcohol syndrome among American Indians. Alc Hlth Res World 7:3-9, 1983

14. Sokol RJ, Miller SI and Martier S: Preventing fetal alcohol effects: A practical guide for Ob/Gyn physicians and nurses. NIAAA, National Clearinghouse for Alcohol Information, Rockville, Maryland

STATEMENT OF FULTON T. CREWS, PH.D., DEPARTMENT OF PHARMACOLOGY, UNIVERSITY OF FLORIDA, GAINESVILLE

Senator CHILES. And now we will hear from Mr. Fulton T. Crews of the Department of Pharmacology at the University of Florida, Gainesville. Dr. Crews, we are glad to have you here today.

Dr. CREWS. Thank you, Senator.

As a member of the College of Medicine at the University of Florida and a member of the Research Society on Alcoholism, I would like to comment that alcohol, although it is the oldest drug, one of the oldest drugs, probably consumed by humans for more than 2,000 or 3,000 years, we really have a very poor understanding of its pharmacology. Recently, we have begun to gain an understanding and to improve our understanding of how it impacts on the health of Americans.

My research has focused on membranes and how alcohol affects membranes, particularly in the brain. We have found that certain neurons are much more sensitive to the effects of alcohol and that this adapts or changes while people are drinking alcohol.

That is, the membranes actually become resistant to the effects of alcohol. And we think this is very much related to the tolerance and the genetic factors that relate to alcoholism, and perhaps to preference for drinking alcohol, which is clearly important.

But in addition, I would like to point out that basic membrane research that is funded through alcohol research and even the effects of alcohol on our membranes also impacts on cardiovascular disease, on liver disease, and other types of drug abuse, and that these are important areas to consider.

Our own research has taken a recent twist in studying alcohol and membranes and the recent interest in the AIDS virus. We recently, in collaboration with some people at NIH, found that the AIDS virus has a very strange membrane, and that alcohol affects that membrane of the virus. And thus our research may expand then into the virus.

Finally, I would like to say that alcohol is one of the most complicated drugs that there are. That is why it has been around, and we still do not understand its pharmacology.

It contributes nutritional value, that is calories, to an individual. And we drink much more alcohol than—normally a small drug, you think you take a little tablet, a few milligrams of drug. Alcohol is consumed in the grams amounts, it is consumed in large amounts, and this makes it complicated.

And this is one reason I feel that training specifically in the area of alcohol is essential, because people need to study alcohol as a unique drug because of its complications. It is very hard for someone in neuroscience to really move to the field of alcohol because of these complications.

Finally, I would like to argue in support of the professional judgment budget because I feel that the impact of alcohol on the health of Americans is totally underrepresented in our research. I read somewhere that it is estimated that 15 percent of the health problem in America is related to alcohol abuse. I think that is probably underestimated because we do not understand the actions of alcohol.

If you look at the total budget for biomedical research, it is clearly not—the effect of alcohol on the health of Americans clearly does not become represented in the biomedical budget through NIAAA.

Thank you for listening to me.

PREPARED STATEMENT

Senator CHILES. Thank you very much. It has been a pleasure.

Dr. CREWS. And should you walk across Florida again in the coming years, please come through Gainesville.

Senator CHILES. I will try to do that. Thank you, sir.

[The statement follows:]

Statement of Fulton T. Crews

I appreciate the opportunity to comment on pharmacological research concerning alcohol and alcoholism. I am an Associate Professor of Pharmacology at the University of Florida College of Medicine. I have studied the pharmacology of alcohol (e.g. ethanol) for more than a decade, first at The University of Michigan and later at the National Institutes of Health. I am a member of the Research Society on Alcoholism and have devoted most of my career to understanding the effects of alcohol on the brain.

Alcohol is one of the most widely used and complicated drugs. It is consumed in large amounts when compared to other more potent drugs, and it has significant caloric value such that it actually represents a food as well as a drug. These factors and others make alcohol a far more difficult drug to study than many other abused drugs. My research has focused on the actions of alcohol on neuronal membranes and neuronal communication. Throughout the past decade data from my laboratory, as well as others, have suggested that the actions of alcohol are in part related to the ability of alcohol to disrupt the membranes of nerve cells. During the past few years we have found that the sensitivity of different neurons to alcohol varies widely between different brain regions. For example, the membranes of neurons in the cerebellum, a brain region involved in coordinated movements, are very sensitive to disruption by alcohol. These studies may explain the sensitivity of tasks such as typing, driving reflexes, and other complicated movements to disruption by alcohol. Additional research is necessary to clarify this relationship.

We have also studied the effects of prolonged alcohol consumption on the membranes of nerve endings, e.g. synaptosomes. Cerebellar synaptosomes change their physical properties becoming resistant to disruption by alcohol. This "membrane tolerance" compares with the behavioral tolerance, essentially decreased sensitivity to alcohol's behavioral effects, known to occur with chronic alcohol drinking. Breeding experiments in rodents have linked genetics to alcohol sensitivity, preference, and certain alcohol induced pathologies. Thus, our understanding of the genetic and biologic differences in responses to alcohol is rapidly advancing.

Genetics are known to contribute to "a taste" for alcohol in several mammalian species with humans being the most obvious. Recent studies on children have found that the children of alcoholics have more behavioral tolerance to alcohol than the children of non-alcoholics. These children never experienced alcohol, except in utero, suggesting a genetic link between tolerance and preference for drinking alcohol. Taken together, these studies are beginning to explain the pharmacology of alcohol abuse as well as the toxicology. Basic research is advancing rapidly in our understanding of the neuropharmacology of alcohol abuse. Numerous therapeutic approaches may result from these basic studies. The recent promising discoveries in alcohol research are likely to lead to a number of therapeutic advances encompassing a significant portion of Americans.

Alcohol and alcohol-related disorders approach 15% of the national health bill (Science, March 6,1986 p.1132). Alcohol and alcohol-related disorders span a broad spectrum of nervous system, hepatic, metabolic and cardiovascular diseases, dietary deficiencies, social problems and other areas, some of which are still unknown. Recreational alcohol is likely to remain a permanent part of our society. Medical research in the pharmacology of alcohol is on the verge of greatly increasing our understanding of the causes of alcohol health problems. The more quickly we can develop therapies through our understanding of alcohol's pharmacology, the greater the saving in the health of Americans and all humans.

The funding of alcohol research has not reflected the importance of alcohol to the health of Americans. Research is constantly discovering new areas of alcohol related health problems. The recent discovery of the potent and permanent effects of maternal alcohol consumption on the fetus have created a major new area of alcohol's pharmacology. These discoveries have changed my lectures to medical students on the neonatal effects of alcohol. I hope the data from these discoveries have already had an impact on the drinking of pregnant women. This example is only one of a number of important health related discoveries on the pharmacology of alcohol which have expanded the significance and potential of improving the role of alcohol in the health of Americans. The expansion of discoveries requires a greater commitment to harvest the rewards of these discoveries.

The Research Society on Alcoholism, of which I am a member, is composed of basic and physician scientists. The excitement generated by the many recent and promising discoveries is clearly constrained by the N.I.A.A.A. budget. The complicated pharmacology of ethanol requires special training which has been very limited considering the extent of alcohol use among Americans. I encourage the committee to follow the professional judgement budget recommended by the Research Society on Alcoholism.

STATEMENT OF EDWARD P. RILEY, PH.D., DEPARTMENT OF PSYCHOLOGY, STATE UNIVERSITY OF NEW YORK AT ALBANY

Senator CHILES. Now we will hear from Dr. Edward P. Riley, a Ph.D. at the Department of Psychology at the State University of New York, Albany.

Dr. RILEY. One of the problems with being the last speaker is everything you wanted to say has already been said by one of my colleagues.

But thank you for the opportunity to testify here. My name is Edward Riley and I am a professor of psychology at the State University of New York at Albany. I have been involved in alcohol research for the last 14 years, and most of that time has been looking at the effects of prenatal alcohol exposure on subsequent development.

As Dr. Sokol pointed out, alcohol abuse during pregnancy is a major health problem in this country, and it may be that over 10,000 infants are born each year with the fetal alcohol syndrome, this full-blown constellation resulting from having a mother a chronic alcoholic during her pregnancy.

It is a tremendous economic impact, over $300 million a year in just dealing with these children with the fetal alcohol syndrome. The social and emotional impact can not even be stated.

The problem is that the effects of prenatal alcohol exposure appear to lie in a continuum. The fetal alcohol syndrome only represents one extreme of the possible outcomes.

What we have been doing in my laboratory, primarily using an animal model, is looking at the effects of lower dose exposures, where you do not produce the physical abnormalities that one sees in the fetal alcohol syndrome. And what we find is that one can produce behavioral problems, such as attentional deficit disorders, learning deficits. One can get overactivity or hyperactivity in these animals whose mothers consumed alcohol that do not produce any gross malformations in these animals.

What I believe is that we need additional research to help identify the types of behavioral problems one can find following prenatal alcohol exposures at doses that do not produce these more obvious physical malformations. We need to look at thresholds of exposures that produce these types of effects. What are safe levels of drinking? Is there a safe level of drinking?

We need to do some research to identify when during pregnancy the fetus is most susceptible to these types of outcomes. We have to do research to identify what types of mothers, what genotypes, may be very susceptible to having a child with fetal alcohol syndrome.

We need to employ the technologies that are available to determine the mechanisms by which alcohol damages the fetus. We need to examine those other possible effects that alcohol could have, such as damage to the immune system in this fetus.

And most importantly, we need to demonstrate what are the best therapies for treating children with these fetal alcohol effects should they happen.

I think this research has lots of practical applications that one could benefit from almost immediately. Hopefully, it would reduce the number of children born with these types of disorders.

I think we could give special attention to the early identification of problems and that would allow for early intervention and the better treatment. I think we could look for more effective treatments for treating these behavioral problems.

PREPARED STATEMENT

I endorse the alternative or the professional judgment budget for NIAAA. I believe that with that level of funding we can make significant strides in dealing with the problem of alcohol abuse during pregnancy and alcohol abuse in general.

I thank you for your time here today.

[The statement follows:]

STATEMENT OF EDWARD P. RILEY

I am a Professor of Psychology and the Director of the Center for Behavioral Teratology at the State University of New York at Albany. I have been involved in alcohol research for the last 14 years and for most of this time I have been investigating the effects of prenatal alcohol exposure on subsequent behavioral development.

I would like to lend my endorsement to the alternative budget proposal for NIAAA, the "Professional Judgement Budget." This alternative budget proposal calls for a fiscal year (FY) appropriation for 1988 of 111.4 million dollars. Of this, $89.5 million would be available for research support and $4.4 million would be used to support research training. The Administration's proposal of $81.7 million for FY 1988 provides for only 89 new and competing project grants which is a reduction of close to 24% compared to the number appropriated by Congress in FY 1987. It also caps the total number of project grants at fewer than the number appropriated in 1987. Even to meet these reduced levels, grants would have to be cut an average of 5%, which in many cases would seriously undermine ongoing research. The Administration's proposal would also have other severe consequences. The number of research trainees would remain at 125 limiting the nation's supply of trained researchers in the alcohol field. Contracts to provide essential epidemiological and treatment research would be reduced significantly. Similarly, program support needed for a variety of projects and services would be constrained. The long-term effects of such a budget proposal can only be surmised, but in my opinion, it would effectively compromise ongoing research and limit many new initiatives in the alcohol field. The alcohol research field has been growing steadily for the past few years and the influx of new investigators has produced substantial gains. Cutting back from this steady growth could undermine these recent gains.

As an alternative to the Administration's budget, the Professional Judgement Budget provides for a 20% increase in the number of research project grants supported by NIAAA. It also allows for 130 new and competing projects to be fully funded amounting to a 10% increase over the number awarded in 1987. The additional money would provide support for high priority research including studies to identify biochemical markers of genetic susceptibility to alcohol related problems; research on mechanisms of alcohol tolerance and dependence; and the identification of an objective marker of alcohol consumption which would be clinically useful. The alcohol research centers would also be fully funded under this proposal and a new center could be created. The number of research trainees would also be increased to 203 allowing for the future availability of well-trained men and women in the alcohol research field. Clinical training support would also be available to help the health profession integrate alcohol education into their core training program. Importantly, high priority intramural research could also be initiated. As relates to my own research interests, the latest NMR technology could be utilized to study the processes by which alcohol damages the fetus as a result of maternal alcohol abuse.

The Professional Judgement Budget also calls for an expansion of the Research Scientist Development Award program. As a receipient of an RSDA, I can appreciate the significance of this program. It has allowed me to devote full-time work to alcohol research and to increase my research productivity immensely. Furthermore, it has allowed me to attract others into the alcohol field, since my state salary could be used to hire additional people. The expansion of this program is certainly a high priority. Another feature of this proposal that I believe is important is the provision for alterations and renovations support to extramural research scientists. With the new NIH guidelines for animal welfare, there are many researchers that will need these funds to renovate laboratories if they are to continue their level of research productivity.

Over the past several years there have been a number of significant advances related to alcohol that have been derived as a result of funding from NIAAA. These advances span the spectrum from gains in our understanding of how alcohol affects membranes and neurotransmitters to showing that impairment from alcohol can last hours after significant blood alcohol levels are no longer present. The recent identification of a drug (RO 15-4513) that specifically reverses some of alcohol's effects on the central nervous system is exciting and potentially important in understanding alcohol's action. Similarly, the work with selected lines of rodents differing on alcohol related traits may provide useful information in identifying biochemical factors that play a role in the etiology of alcohol related pathologies. The work on the genetics of alcoholism in humans is also exciting and may pave the way for the early identification of individuals at risk for alcoholism.

As I stated, my current interest in alcohol research is the effect of prenatal alcohol exposure on subsequent development. Alcohol abuse during pregnancy is a major health problem in this country. The incidence of the fetal alcohol syndrome (FAS) is estimated at 1 to 3 cases per 1000 live births. Taking 2 per 1000 live births as an average, this translates to over 7000 children that are born each year in the United States with FAS. The economic costs for dealing with this problem have been estimated to be over 300 million dollars per year. Perhaps even more significant is that FAS is thought to be the leading known cause of mental retardation in the western world and the obvious social and emotional impact can simply not be put into financial terms.

Importantly, the effects of prenatal alcohol exposure appear to lie on a continuum and FAS only represents one extreme of a spectrum of abnormalitites. There is good evidence that cognitive impairment and behavioral abnormalities, such as attentional deficit disorders, can occur in children exposed to alcohol prenatally in the absence of the physical signs associated with FAS. The incidence of these functional effects of prenatal alcohol exposure is estimated to be significantly higher than that of FAS and the costs, in terms of the limitation on the quality of life, are obviously enormous. The tragedy is that these fetal alcohol effects are fully preventable.

We need additional research to help identify the types of cognitive and behavioral problems associated with prenatal alcohol exposure. We need research aimed at looking for thresholds of exposure levels that produce these types of problems and when during pregnancy the fetus is most susceptible to alcohol-induced behavioral problems. Research on identifying women at particular risk for having a child with fetal alcohol effects needs to be conducted. We need new research using the latest technology to help determine the mechanisms by which alcohol causes damage to the fetus and other functional consequences related to prenatal alcohol exposure, such as damage to the immune system. We need to determine the best possible therapies to treat or mitigate these fetal alcohol effects.

Within the Center for Behavioral Teratology at SUNY-Albany, we have several projects related to fetal alcohol effects. One of our primary concerns is to further expand our animal model to study these effects. We have found that animals exposed to alcohol prenatally show learning deficits and are hyperactive, as are children exposed to alcohol in utero. We are currently investigating attentional deficits in these animals. Hopefully, by identifying various behavioral abnormalities in these animals, it will allow for the early recognition of behavioral problems in children that result from prenatal alcohol exposure. Also, we have, and are continuing to try, various behavioral and pharmacological treatments to mitigate these behavioral effects. An important aspect of our work is that we are able to assess these fetal alcohol effects over the life span of the individual in a reasonable amount of time, something that is not possible in prospective human investigations. Another line of inquiry is concerned with identifying when during pregnancy these alcohol related behavioral problems are caused. If we find that, unlike many of the physical problems associated with alcohol exposure, the learning deficits and other behavioral problems are associated with exposure late in gestation, then this may provide an important impetus for women to stop drinking during their pregnancies. Not all women who drink have children with fetal alcohol effects and we are trying to identify factors using our animal models that may predispose some individuals to be at greater risk for children with fetal alcohol effects. We are interested in determining if sensitivity to alcohol might be a predisposing factor. Future plans call for us to see if parity or age might influence fetal alcohol effects.

This research could have immediate practical application and hopefully reduce the number of infants born each year with fetal alcohol syndrome and fetal alcohol effects. Children with learning deficits associated with prenatal alcohol exposure could be treated appropriately and special attention could be given to the early identification of behavioral problems in these children to allow for early intervention.

Alcoholism and alcohol abuse is a national health problem affecting over 18 million adults in this country and accounting for between 10% and 15% of the Nation's health care costs. Alarmingly, the use of alcohol by the Nation's young appears to be on the increase. It is tragic enough that their alcohol abuse may impact their lives, but it is worse that it may impact the lives of their children. We need a responsible program for dealing with alcohol abuse in this country and adequate funding for alcohol research if we are going to make headway against this problem. Thank you for your time and consideration.

SUBCOMMITTEE RECESS

Senator CHILES. Thank you very much for your testimony.

The subcommittee will now be in recess until 9:30 tomorrow morning.

[Whereupon, at 5:05 p.m., Thursday, May 7, the subcommittee was recessed, to reconvene at 9:30 a.m., Friday, May 8.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1988

FRIDAY, MAY 8, 1987

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:35 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Lowell P. Weicker Jr. presiding.

Present: Senators Chiles, Burdick, and Weicker.

NONDEPARTMENTAL WITNESSES

Senator WEICKER. This is the last day of testimony from public witnesses. After it is over, we will have heard from 206 persons. I might add the testimony has been extraordinary. I think it has adequately expressed the problems, the opportunities and the desires of the people of this Nation. I want to thank all of those who have testified and those who will testify this morning.

I am only going to be able to stay for a few minutes this morning, and Chairman Chiles is going to take over. I might add he has done an extraordinary job in conducting not only these hearings but chairing the Budget Committee.

I am sure that he would want me to attend to those duties because I intend to go to the floor to comment upon my very dearest friend, Stewart McKinney, who passed away yesterday. I think what it does, really, is it brings home the point that our problems are not confined to people outside the realms of power in Washington. Rather, they are the problems that belong to all of us, regardless of our position in life.

Life is a very precious thing, and I suppose that is why I get a joy out of serving on this committee, because the business of this committee is to tend to that precious thing called life. All I can say is that he gave so much of his time to the State of Connecticut particularly, and the District of Columbia and all of those that needed his special care. These were the works of Stewart McKinney, and all of us owe him so much.

There is a witness list, and there are a few persons who have expressed a particular problem, and I would like to accommodate them if I could. I do not think it will create too much of a problem here.

I wonder if David Bradley of the National Community Action Foundation is here.

David, would you like to go ahead and testify?

I do have the unpleasant duty of keeping everybody to 3 minutes, only as an accommodation to all of you so that all of you can be heard and so that the last few do not get relegated to having everybody yawning, waiting to get out of here. So if you could, please keep it to 3 minutes.

All statements will be included in the record in their entirety.

STATEMENT OF DAVID BRADLEY, NATIONAL COMMUNITY ACTION FOUNDATION

Mr. BRADLEY. I appreciate this opportunity to share some thoughts with you concerning the Community Services Block Grant, and I will be brief.

Let me say at the beginning every criticism and every concern that has been raised about this program by the administration has been answered either in the General Accounting Office report of 1986 or the very extensive reauthorization process we went through last year. Consistently, a standard by community action agencies' work through the Community Services Block Grant is the unique ability of meeting local needs.

In Florida, we can go back to the Liberty City incident, where the community action agencies [CAA] played the real bridge role after that crisis in getting vendors back into the area and helping rebuild.

In Iowa, a State with a very troubled economy, community action agencies are a very integral part of the State's economic and social structure. Whether they are farmers in trouble, senior citizens in need, or rural economic projects, family self-sufficiency models designed to get people off of welfare, they all encompass community action agencies, and they are all a part of the very comprehensive State strategy.

In California, it is the CAA's that are taking the lead on immigration reform and the things that we are doing with amnesty right now.

State after State, ranging from Massachusetts to Oregon, Washington, Florida, the Sun Belt States, Connecticut, community action agencies are the lead on the homeless issue.

So our funding needs are pretty simple. One, we need a $250,000 to $500,000 pot for training. There is no training for a basically $2 billion program. When you encompass the other problems that we administer as well, you need a small, tight, very well drafted training.

Two, the demonstration partnership fund. This committee funded it last year, $1 million. The regulations just went out last Friday, and I am confident that the future of this program rests in that pile of money. Ideas that are flourishing and coming forward, by the time you mark it up will be quite exciting.

Three, protect the block grant and the discretionary funds to the best of your ability.

Four, please keep an eye on the fact that both House and Senate authorizing committees, Appropriations Committees as well as a whole host of other committees anticipate a major role for community action agencies in the problems of the homeless. Everything, every factor that is coming forward uses community action agencies in some way. If there is going to be a commitment to that program beyond 1 year, beyond fiscal year, just take that into account.

Thank you.

PREPARED STATEMENT

Senator WEICKER. Thank you for all the good work that you do, also.

[The statement follows:]

STATEMENT OF DAVID BRADLEY

Good afternoon, I am David Bradley, here today on behalf of the National Community Action Foundation, which is the Washington representative of the nation's 900 Community Action Agencies. Mr. Chairman, I am grateful to be able to testify in front of this committee.

The Administration has requested a reduction in the Community Services Block Grant (CSBG) of over 16 percent in FY 1988, a first step toward phasing out the block grant entirely in 1990. The rationale used is that the gap caused by reduced CSBG monies can be filled by other funds such as Social Services Block Grant, Head Start, Low Income Energy Programs, Community Development, Job Training and others.

Mr. Chairman, each of the programs named by the Administration as well as all other social programs are fighting to maintain their own level of funding and service. They do not have excess funds to replace lost CSBG money. They also have their own program purposes which are different from those of the CSBG.

The Community Services Block Grant fills unique purposes that were identified in the study conducted by the General Accounting last year as

- providing programs for the poor that fill local needs unmet by other programs and
- That "because of its flexibility, CSBG is often used to support CAAs' administrative operations. Other federal and state programs often do not provide sufficient administrative cost funding to support the management of their individual programs, let alone the operation of the CAA itself." Specific programs that were cited by GAO that fit this category were Surplus Commodity Food Distribution and Low Income Home Weatherization.

GAO went on to say that the loss of CSBG funds could influence the ability of CAAs to continue operations.

An indication of the high level of performance achieved by CAAs is the degree of support that they currently receive from public officials. More governors, state legislators, city and county officials are supportive of CAAs that at anytime in the program history. Both the House and Senate budgets are treating the Community Services Block Grant favorably. And, major legislation dealing with the Temporary Emergency Food Assistance Program (TEFAP), the homeless and, quite possibly, welfare reform, recognize the contributions that CAAs are making to the low income.

In many localities, CAAs have taken on the role as the lead agency to mobilize resources and deliver services to the homeless. In a number of states they have this role because the governor has designated them as the lead agency. Both House and Senate homeless bills that are currently in process anticipate the designation of CAAs to operate a share of the local program activity.

Mr. Chairman, I am as concerned as any citizen about the dangers of the deficit, not only for FY 1988, but for the challenges it poses for future domestic spending. On that basis we are keeping our funding request for this year to a minimum. It is as follows:

1. That the basic block grant be funded at its current level and not be cut;

2. That the discretionary fund be maintained at its current level;

3. That you carefully consider adding another $2 to $3 million to the Demonstration Partnership Program. The

award notice for this program has not been issued yet, but even the Administration officials associated with this program are becoming excited because of the potential programs for addressing the problems of poverty they are beginning to hear about from CAAs. It is this program that is bringing these innovative ideas and approaches to the surface.

4. Another funding need is for $250 to $500 thousand for training. All training programs and funding for training was lost when the Community Services Administration was abolished. However, the need for training has not diminished.

   One of the most crucial areas that needs to be addressed is for new program administrators in how to do their jobs. There is significant turnover of state CSBG officials and of CAA directors and in order to continue the high performance of the program, they need to receive intensive training which is not currently available.

5. Finally, if homelessness continues to be a priority and does not fade as the anti-drug campaign did, I recommend that CAAs be recognized for the work they are doing with the homeless.

Thank you Mr. Chairman for your time and support.

STATEMENT OF EUNICE SHATZ, PH.D., EXECUTIVE DIRECTOR, COUNCIL ON SOCIAL WORK EDUCATION

Senator WEICKER. Dr. Eunice Shatz, executive director, Council on Social Work Education.

Dr. SHATZ. I appreciate the full support of this committee and particularly of you, Senator Weicker, in supporting and understanding the need for trained professionals to deal with the problems of human distress, and I thank you for the opportunity to testify.

I would like to stress the need for expansion of training and research in three major areas, if I may, the first being child welfare. In spite of the extension of services, abuse and neglect have escalated in the areas of sexual abuse, hunger, and physical battery. In extreme, children are raped, they are battered, and they are dying.

There is a need for a new initiative to deal with the problem, and that is in the form of training and research centers collaborating with child welfare agencies in order to provide specialized and focused multidisciplinary education for work in public child welfare systems.

We are proposing a $5 million appropriation that would support 10 to 20 of these centers with a State match required of matching funds to specifically train people to work in this field.

On a related matter to this, we also strongly oppose the administration's proposal to consolidate all human services budget authority within one department, with that department setting priorities and allocating funds at their discretion. We do not believe that this process will improve the priorities that are set by Congress with which we are very satisfied.

The second area of need I would like to mention briefly has to do with chronically mentally ill persons who make up about 35 to 40 percent of the population of homeless persons about which there is a congressional initiative being proposed now. This proposal really links to that initiative in that it is suggesting doing something about the scarcity of trained professionals to provide service to this population.

We join with other service providers to request a redirection of the mental health training priorities to focus on chronically mentally ill persons, the creation of a new $10 million clinical training program to create joint training between universities and State agencies and community mental health centers with the assurance of job availability for graduates of that program and grant termination if the graduates fail to enter the positions that have been created to serve this population.

In a related area, we also are proposing an expansion of training focused on providing vocational rehabilitation services to support the current programs of employment and independent living to this population. It is fast becoming one of the major elements in the case load of rehabilitation today.

Finally, I would wish to bring to your attention the effects of the shortening hospital stay for aged and disabled persons which results from the DRG prospective payment system. Heightened significantly is the need for discharge planning which has long been the responsibility of hospital social services staffs, and we urge funding for special training of social workers and others to identify patients in need of special post acute care and arranging for that treatment.

Training in all these areas is essentially preventive, I would argue, in that it allows the handling of problems before they get worse and before they get larger. Research is the vehicle that tells us if we have made a difference and, if so, how we have made a difference and where we have made a difference. You, the Congress, as well as we, the educators, need to know that, and I thank you for the opportunity to bring it to your attention.

PREPARED STATEMENT

Senator WEICKER. Dr. Shatz, thank you very much for your testimony. It is greatly appreciated by the committee. Thank you.

[The statement follows:]

STATEMENT OF EUNICE SHATZ

This testimony is presented on behalf of the Council on Social Work Education of which I am the Executive Director. The Council is a nonprofit membership association of graduate schools and undergraduate programs of social work as well as individual faculty members and associated organization. The Council is the national organization of the schools and programs of social work education and it's mission is to further the goals of education and research in social work. It is also the accrediting organization for these schools and programs.

Thank you for this opportunity to testify on the training and research needs of social work education. My testimony deals with the professional training programs of the Office of Human Development Services (OHDS), the National Institute of Mental Health and the Health Resources and Services Administration, all in the Department of HHS, and the Rehabilitation Services Administration of the Department of Education. My testimony also deals with the research budgets of the OHDS and NIMH and the service programs.

This Subcommittee has been very supportive of human service programs generally and of the need for the training of professionals to provide those services. We appreciate fully the support you have provided. Without it, there would not have been adequate numbers of trained people to provide mental health, maternal and child health, child welfare and other services.

We wish to stress this year the need for an expansion of training and research activity in two areas: child welfare and chronic mental illness.

In the past decade, there has been some expansion of child welfare services financed by the federal government.

Unfortunately, however, the problems of abuse and neglect of children continue and the rate of problems seem to increase.

We think that federal support for child welfare services needs to be further expanded. We also believe that a new initiative should be established to create research and training centers working in collaboration with state child welfare agencies. These programs would provide assistance to the state agencies regarding improved methods of providing child welfare services and would train individuals with a particular focus on the needs of the public child welfare system. Such training could be long term training and continuing education. A $5 million appropriation would support between 10 and 20 of such research and training centers. States should be required to provide some matching funds for these centers. The centers, while located in social work schools, must be multi-disciplinary involving at least medicine, law and public health. This program would not be a replacement for the existing child welfare training program. The existing program provides student financial aid to needy students seeking training and employment in the child welfare field.

The new $5 million initiative should be supported from both the child welfare research and training authorities.

On a related matter, we strongly oppose the Administration's proposal to consolidate all human service budget authority in one budget account. Under this approach, all headstart, child welfare, adoption assistance, native american, aging and developmental disabilities funds would be allocated to the Department in one budget account, with the Department retaining discretion to allocate the funds, at will, among the program areas. We think the results of such a process would not improve the effectiveness of these programs at all. We have been very satisfied with the Congressional priorities regarding the allocation of funds among service programs for the aged, disabled, native Americans and children. We would urge that more funds be appropriated, however, in the various accounts.

With regard to mental health, we are concerned about inadequate services to the chronically mentally ill. Mental health service providers have correctly raised problems about the lack of trained professionals to deal with those suffering from chronic mental illness. We join these service providers in calling for a redirection of the mental health training program's priorities. We recommend the creation of a new $10 million clinical training program which focuses on training mental health professionals to serve those with chronic mental illness. Grants should be made to universities which establish joint programs with state mental health agencies or community mental health centers. The programs must focus on training, including clinical experience, regarding services to those with chronic mental illness. Service agencies which join in these projects must give assurance of permanent jobs being available to the trainees. Grants should extend to five years, but should be subject to termination if the trainees, upon graduation, do not enter positions providing services to those with chronic mental illness.

We also recommend that the existing mental health clinical training program be continued at the $15 million level of FY 1987, at least. Training needs in mental health areas other than chronic mental illness still exist and these funds are necessary to assist qualified, needy students to be trained in mental health.

In a related field, rehabilitation, we recommend an expansion of training programs with a specific focus to be added on training social workers to provide vocational rehabilitation services to the chronically mentally ill. Vocational rehabilitation services now include new programs related to supported employment and independent living and these programs are very relevant to the chronically mentally ill. They are becoming one of the major elements in the caseload of rehabilitation. We would recommend a joint NIMH - RSA initiative in this area.

We also urge the Subcommittee to at least continue at current levels training funds in the maternal and child health and aging programs.

We would like to bring to the Subcommittees' attention, our concern with the effects of the shortening of hospital stay for th aged and disable under the Medicare program as a result of the D.R.G. prospective payment system. The new payment system places increased burdens on home health agencies, outpatient programs, and nursing homes which now must deal with patients who have had less acute care in a hospital setting. Of particular importance in dealing adequately with these new burdens is the process of hospital discharge planning which has long been the responsibility of the hospital social work department. The October 1986 Medicare amendments, referred to as OBRA, have required hospitals to put in place a sophisticated discharge planning process aimed at identifying patients in need of post acute services and arranging for those services. We would urge this Subcommittee to appropriate funds for special training of medical social workers and others involved in discharge planning. Training should be both short term and long term and should focus on interdisciplinary efforts regarding the effects of the new payment system, the types of patients most at risk and the various types of programs which may be best able to meet the post acute care needs of patients. Funds from the Administration on Aging, the National Institute on Aging, the Rehabilitation services Administration and HRSA are relevant to this effort.

STATEMENT OF KENNETH T. BLAYLOCK, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Senator WEICKER. Ken Blaylock of the American Federation of Government Employees. Welcome, Ken.

Mr. BLAYLOCK. Thank you very much, Mr. Chairman.

Mr. Chairman, you mentioned earlier in your remarks about brother McKinney, that we are really all about life and all about people, and that is very true. The program that we are talking about here today, the Social Security Program, is about life, and it is about people. It is about those 38 million people that depend on the program for a little better life in their older years. It is about the 122 million people that are now paying into that account, hoping it will also provide the same benefits for them in their older years.

It is about 65,000 Federal workers who are trying to keep up with those accounts and keep those benefits flowing and process the claims and what have you, and that is what I am here today for.

Before you is a proposal from OMB and this administration to reduce the number of Social Security workers by 20,000 over a 5-year period. Last year's budget cuts put us in a position within the agency that we do not have enough people to do the job today. I can give you literally stacks of affidavits from Federal workers throughout this country that will give you the horror story of what is happening.

Now, they claim that because of modernization we are able to reduce, and we do not object to the modernization program. In fact, we welcome it. The program, however, as found out by GAO in report after report, is way behind schedule. The equipment that they thought they bought was not what they thought they had, and that has to be rebuilt. In the meantime, Mr. Chairman, we have to try to keep the program moving.

As an example, 127,000 beneficiary notices are not mailed yet, to our knowledge. We know that they were laying in an office in Baltimore over 90 days late going out. To give you the significance of that, there is a timeframe. The beneficiary has 60 days to appeal to the Government when they get those notices to try to correct their accounts. These did not go out until after the legal timeframes had expired. So what that means, in each district office throughout this country, those people will be coming forward with appeals, but they will be untimely and we will go through even a heavier workload in trying to straighten those out for the people.

Mr. Chairman, we have added some 9 million people to the Social Security rolls with the tax amendments of last year. We are also adding probably another 4 or 5 million people with the Immigration Reform Act. This year's proposal just simply puts us in the position, Mr. Chairman, where we do not have the people to do the job.

In our testimony, as I said, we will be more than glad to provide the committee with all the affidavits we have. My role here today, we simply are asking, one, that you keep these things in mind; and two, we have to operate this program until we do really get the modernization system on the line. We would ask that this committee establish a personnel floor, that you maintain sufficient people to get this job done until we do shake the new system out and get it on the line in the proper way.

Mr. Chairman, that summarizes my remarks, and I appreciate the opportunity to appear here.

Senator WEICKER. Ken, I appreciate your comments. Believe me, we all appreciate the work that the members of the American Federation of Government Employees do with you as their head, and I think they do outstanding work. I realize that it is the fashion to go ahead and criticize Government employees.

PREPARED STATEMENT

Thank you very much. I think we have the finest in the world, and you represent them.

Mr. BLAYLOCK. Thank you very much, Mr. Chairman.

[The statement follows:]

STATEMENT OF KENNETH T. BLAYLOCK

My name is Kenneth T. Blaylock. I am the National President of the American Federation of Government Employees (AFGE). AFGE represents some 700,000 government employees, including those who work for the Social Security Administration (SSA).

Mr. Chairman, back in 1983 with the passage of the Social Security amendments, Congress made important strides in reestablishing confidence in the Social Security system. Income is now exceeding outgo. The OASDI Trust Fund balance is projected to go from $38 billion in 1986 to $96 billion in 1988. Long-term projections show the Social Security Trust Fund to be on sound footing well into the next century.

However, we fear that the confidence established by Congress's actions is being eroded by poor management decisions.

We have reviewed the Social Security Administration's budget justification for fiscal year 1988. We have closely reviewed the Commissioner's written testimony. The justification and SSA's testimony do not match our own experiences and information of Agency needs in administering what is arguably the nation's most important domestic program. The Agency's budget request is grossly deficient to handle the projected workload.

As you know, the Department and Agency under the direction of the Office of Management and Budget have been engaged in a five year plan to reduce Agency staffing by 17,006 by 1990. An internal Departmental document shows that the OMB is now calling for an additional 3,000 position reduction by 1992, bringing the total staffing reduction to 20,000. The rationale for this reduction is basically two-fold, systems modernization and productivity improvement, often referred to by the Agency as "administrative efficiencies".

First, let me state unequivocally that our union is not opposed to systems modernization and technological improvement. We are in favor of modernization that aids our workers in serving the public. However, as documented in a series of GAO reports, the SSA's systems modernization program is in serious trouble and well behind schedule. GAO says the system is untested and even recommends that the recent terminal purchase be renegotiated and further acquisition be postponed until the system can be tested according to industry standards. The SSA's response was to purchase the 22,000 terminals for installation by the end of FY 1988. As recently as April 2, 1987, in testimony before the House Ways and Means Subcommittee on Social Security, Mr. Richard L. Fogel, Assistant Comptroller General for Human Resources Programs of the GAO, said:

> "The program is so far behind schedule that we do not believe that some of the staff savings SSA estimated by 1990 as a result of computer modernization will be realized."

Mr. Chairman, while addressing the systems modernization area, let me make a special plea that the $64.7 million already appropriated for furniture acquisition related to systems modernization not be reallocated as requested by the Agency to what it calls "...regular administrative expenses in FY 1988". As already mentioned, the Agency plans to install, by the end of FY 1988, 22,000 new computer terminals. In order that these terminals be used most productively and the employees' health and safety be protected, we request that appropriate ergonomic furniture be installed simultaneously with the 22,000 terminals.

There is no dispute between the Agency and the Union on the need for this ergonomic furniture. In a report prepared by a joint Union/Agency team, and agreed to by myself and Herbert Doggette, Deputy Associate Commissioner for Operations, it was decided that a priority must be given to supplying employees with needed ergonomic furniture (AFGE/SSA Video Display Terminal Report - Project Team Report, January 24, 1987). The Agency's budget request makes it clear that this is not their current plan (Justification of Appropriation Estimates for the

Committee on Appropriations - Fiscal Year 1988, DHHS/SSA, p.106).

Productivity improvement or "administrative efficiencies" are terms used to justify many of the staffing reductions. According to the Commissioner, she plans to "...reduce the disparity in average workload unit times among geographic regions...." Accomplishing this goal will not necessarily result in overall system's productivity improvement. For example, the HHS Atlanta region used a technique to lower average unit times on paper that is being recommended in other HHS regions. This technique involves instructing employees to take claims from claimants who obviously are not eligible. Those claims are then quickly and easily denied. This drives up the number of cases handled and drives down the average time it takes to process cases.

District Office Final Authorization is another device used to effect staffing cuts. Difficult payment authorization decisions are now being made in the field that were previously made by specialists in SSA Payment Centers. Yet, Agency documents show that payment error rate then goes up dramatically. So minimal savings in staffing are offset by increased payment errors.

Disability applicants are now told to take the application forms home to complete instead of receiving staff assistance. Those applications are detailed and difficult to complete. It saves "processing time" for the agency, however. Once again, this is a questionable method for increasing productivity.

The Agency has made a conscious choice to not encourage or even inform individuals affected by immigration reform (PL.99-003) that there may be discrepancies in the posting of their wages (SSA general series, Denver, 87-02-1/30/87). Why? Because the Agency knows that potentially there is an enormous workload in this area, probably 4,000 - 9,000 FTE's.

Mr. Chairman, we would like to make available to you and your staff literally volumes of material we have been receiving documenting the Agency's deterioration and in the deterioration of service to the public. Some of these materials are returned questionnaires that we sent out earlier this year, others are affidavits received within the last two weeks.

Mr. Chairman, the situation is critical. At the moment, the employees of the Agency cannot properly do their jobs. Not only are there not enough staff, last minute budget cuts last year from the FY 1987 appropriation have resulted in employees having to buy their own pens and paper, and buy their own xerox paper. In one office, this caused a collection to be taken to buy toilet paper for the office. The Agency has set itself up for this situation in its mania to drive down costs--service be damned. The GAO [GAO/HRD-86-8] reports that 25 percent of the people calling SSA offices have to call three or more times just to get through, and we have every reason to believe that phone answering is getting worse. Office supplies are being shipped from field office to field office. In some places, needed forms for claimants are not available. The situation is ludicrous and unnecessary.

With respect to FY 1988, the SSA is asking for an FTE level of 69,345. This request is 5,092 FTEs below the 74,432 FTEs Congress authorized last year. That staffing level was barely adequate. Now we are faced with three major new initiatives this year: 1) The installation of the 22,000 computer terminals and concommitant training time (700 FTEs); 2) Numeration of 9,000,000 new individuals (agency estimate) as a result of last year's tax reform bill (1,600 FTEs); and last and most significantly, 3) Correcting earnings discrepancies as a result of immigration reform (at least 4,000 FTEs). This need for additional staffing is bolstered by a December 11, 1984 memo by them Acting Social Security Commissioner Martha McSteen to the HHS Budget Office Assistant Secretary which clearly states that the ability to reduce personnel is based on an assumption of no new legislative or administrative initiatives creating new workloads. Consequently, we are requesting that this Committee provide funding for 80,737 FTEs. Furthermore, we urge the Committee to include language in the Appropriation Bill which establishes this level as a staffing floor for the Agency.

The Agency has not made a persuasive case; the GAO studies call the whole modernization program into question. The SSA's productivity improvements are largely smoke and mirrors. Employee morale is plummeting. Good, well-trained employees are leaving the Agency daily because of stress and frustration. Is it too much to ask that adequate staff be made available to administer so important a program as Social Security, or to require that HHS and SSA demonstrate clearly and convincingly that their vaunted systems modernization can, in fact, allow staffing reductions? We and the GAO agree--the proof is not yet there.

STATEMENT OF EUGENIA BOGGUS, PRESIDENT, NATIONAL HEAD START ASSOCIATION

Senator WEICKER. Eugenia Boggus of the National Head Start Association.

Ms. BOGGUS. Senator——

Senator WEICKER. Eugenia, pull that microphone up to you so that we can hear you.

Ms. BOGGUS. I am a former Head Start parent and president of the National Head Start Association. I never dreamed I would have the opportunity and honor to come before you today and address you. If it had not been for the confidence and the ability that Head Start seemed to develop in myself, I would not be here now. As president of the National Head Start Association, you are the first group I have had the honor to address.

Senator, we appreciate your strong support for Head Start, and we are very pleased that the Senate version of the budget includes room for significant increase of this important program.

I did not know that it was 3 minutes, and I am just going to run through this.

We hope that this committee will fully support Head Start by seeing that the appropriate funds are raised to the full authorization level, $1.263 billion, in fiscal year 1988.

There are many reasons why it is important for Head Start to be fully funded; for example, enhancing long-term education and employment prospects for Head Start. If I thought you were unfamiliar with the success of Head Start and I had a very long time to speak, I would gladly take time to cover all the reasons Head Start is essential for low income families.

Head Start serves only 16 percent of the 2.5 million of the children who need its services. Today, almost 25 percent of children are under the age of 6 or 4. I got married when I was 16 and started having children, and I have seven children. I had four children before I even heard about Head Start, and I was only able to get two into the program. As a result of an accident, one of my children was blind at the time, so he did not get the benefits of the program.

Across this country today, there are hundreds and thousands of children on waiting lists. Unfortunately, they will still be there when they enter school. It is truly a travesty for those who miss the benefits of Head Start.

Second, other comprehensive preschool options were not available for my children at the time. Head Start was the primary resource for comprehensive early childhood development opportunities for low income children, and that remains true today.

In addition, it is a well-established fact that lack of child care is an overwhelming barrier to employment for low income parents.

Although some States have begun to fund early childhood education programs, the quality and quantity of those programs varies widely. Some States have nondirective legislation in the State school code that merely allows schools to operate a preschool program. Some States actually operate preschool programs which supplement Head Start programs. Teacher/child ratio, hours of operation and teacher qualifications also vary.

Nonetheless, it is unable to reach the entire population because of inadequate funding. Private sector child care is not the answer for most low income families. State preschools do not solve the problem, either. An expanded Federal commitment to Head Start is needed to insure that needy children in every region of the country have access to effective early childhood development programs.

It is impossible to provide a quality comprehensive childhood education program when you have a high staff turnover rate. If we are to successfully impact on poverty or the problems it breeds, we must have a high quality Head Start Program. Head Start has been the challenge and difference in my life and that of my children. If it can be funded so that it can expand while retaining its high quality, it will be that challenge and difference for countless others.

PREPARED STATEMENT

Senator WEICKER. Eugenia, thank you very much for your testimony, and it will be included in the record in its entirety. Thank you.

Yes; we do think a lot of Head Start. We do know about it, and we are very proud of it.

[The statement follows:]

STATEMENT OF EUGENIA BOGGUS

I am honored to be given this opportunity to speak today. My name is Eugenia Boggus. I am a former Head Start parent and acting President of the National Head Start Association (NHSA). I never dreamed I would be given the opportunity or honor of addressing such an esteemed gathering of elected officials. If it wasn't for the confidence and ability Head Start helped me see and develop within myself and if I did not feel so strongly about the importance of Head Start, I would not be here. As NHSA President, you are the first group I have had the honor to address.

It is my sincere hope that this Committee will fully support Head Start by seeing that appropriated funds are raised to the full authorization level of $1.263 billion in FY 1988. There are many reasons why it is important for Head Start to be fully funded, for example: its success in enhancing long term education and employment prospects for Head Start enrollees. If I thought you were unfamiliar with the success of Head Start and I had a very long time to speak, I would gladly take the time to cover all the reasons Head Start is essential for low income children. I do not wish to make it appear as if other reasons for supporting Head Start are not important, but today I want to limit my comments to three issues concerning Head Start that have personally touched my life.

First, Head Start serves only 16 percent of the 2.5 million children who need its services. Today almost 25 percent of children under the age of six are poor. I got married when I was 16 and started having children. I had four children before I even heard about Head Start. When my fifth child was four, I tried to get him into Head Start. Unfortunately, there were no slots available. He was placed on a long waiting list, and he never got into the program. As the result of an accident, he was blind at that time. I can not help but feel that if he had only gotten into Head Start, his life and school days would be different. Across this country, there are hundreds of thousands of children on waiting lists. Unfortunately, they will still be there when they enter school. It is truly a travesty for those so in need to miss the benefits of Head Start.

My last two children were able to get into Head Start. There was such a difference between them and my older children. Head Start stimulated them. They entered school with a sense of confidence that my other children lacked. They held their heads high and had expectations of success. I am proud to say, my youngest daughter is an all A Honor Roll student. Head Start gave her a foundation based on sound, comprehensive services which allowed her opportunities for success, nurtured her self esteem and prepared her for her fist competitive situations in life. She faces each challenge with confidence. My children are not unique. This process happens to some extent for every child who attends Head Start. I have seen it happen many times.

Second, other comprehensive, affordable preschool options were not available for my children. At that time, Head Start was the primary source of support for comprehensive early childhood development opportunities for low income children and that remains true today. In addition, it is a well established fact that the lack of child care is an overwhelming barrier to employment for low income parents. I could not work because I had no place to leave my son. I did not have income sufficient to pay for even minimal child care, much less the level of care my son needed. Private sector child care was not and is not an alternative to Head Start for low income parents.

Although some states have begun to fund early childhood education programs, the quantity and quality of those programs varies widely. Some states have non-directive legislation in the state's school code that merely allows schools to operate a preschool program. Some other states actually operate preschool programs or supplement Head Start programs. Teacher/child ratios, hours of operation, and teacher qualifications are also varied. Unfortunately, despite Head Start's two decades of proven success, most states are spending little money to extend similar services to the millions of children Head Start cannot serve because it is underfunded.

I was raising my children by myself, I needed help and I had nowhere to turn. Low income parents today are experiencing the same problem -- a great need for child care, a Head Start system that provides tremendous support at least for part day but which nonetheless is unable to reach the entire eligible population because of inadequate funding. Private sector child care is not the answer for most low income families. State preschool doesn't solve the problem either. An expanded federal commitment to Head Start is needed to ensure that needy children in every region of the country have access to effective early childhood development programs.

A final and very important reason that I hope Head Start is fully funded concerns the issue of quality. Head Start must retain a high level of quality or else it will fail in its mission. Well-trained staff are an integral part of quality. A high rate of staff turnover continues to threaten the future of Head Start.

When my children were in Head Start, I met some of the most dedicated and talented individuals in the world. Many were former Head Start parents who had gone on to school, others were young energetic college graduates and others mature teachers. To them, Head Start was more than a job: in many ways it was like a calling.

One reason quality staff is so important is because a relationship of trust and confidence must be built between staff and families if positive changes are to occur in a low income home. Families have a lot of pride. They don't want to admit to problems in their homes. I know it has taken a long time for me to be able to talk about my personal life. I still might have not been able to if I had not established a confidential relationship with my son's teacher. She became my friend. I was not her only friend, as all the other parents were her special friends, too, but I knew she was my friend.

Building on that confidential relationship of trust and respect with that teacher, I was able to admit to problems and deal with them. Again, it was not a unique situation. I witnessed parent after parent come in with unadmitted problems. They would slowly build a close and confidential relationship with a teacher or social worker and the home situation would improve.

This close relationship led me to get involved with the Parent Committee which gave me the confidence I so badly needed. In turn, I became even less shy. Skills and abilities that I was afraid to use surfaced without my even knowing it. I went on to get an AA Degree in Child Development. It takes a special staff to encourage and support a single parent with seven children to raise, two under the age of five, over ten years after she has graduated from high school to get a college degree. I was lucky that I had that consistent support, that quality staff.

Unfortunately, that is not always the case. Staff turnover was amazing at our centers. Some Head Start directors have told me, their teacher turnover is fifty percent a year. We encourage our parents to be involved in Head Start training and to get a degree if at all possible. We like to employ them in the centers, but all to often they must leave once they are trained because the pay is so low. It is impossible to provide a quality comprehensive childhood education program when you have a high staff turnover rate. If we are to successfully impact on poverty or the problems it breeds, we must have a high quality Head Start program.

Head Start has been the challenge and difference in my life and that of my children. If it can be funded so that it can expand while retaining its high quality, it will be that challenge and difference for countless others.

STATEMENT OF ALLAN G. BARCLAY, PH.D., ASSOCIATE DEAN FOR ACADEMIC AFFAIRS AND PROFESSOR OF PROFESSIONAL PSYCHOLOGY, WRIGHT STATE UNIVERSITY, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Senator WEICKER. Dr. Allan Barclay of the American Psychological Association.

Dr. BARCLAY. Thank you, Senator Weicker. My comments will be brief.

I want to express my personal appreciation to you and that of many of my colleagues for your strong and dedicated support in the field of mental retardation, developmental disabilities, and associated problems.

Mr. Chairman and members of the subcommittee, my name is Allan Barclay. I am associate dean for Economic Affairs and professor of professional psychology at Wright State University in Ohio. I am here today representing the American Psychological Association to urge you to include funds in the fiscal year 1988 appropriations bill for projects to demonstrate the effect of psychological services for persons with developmental disabilities and their families.

As our time is very limited, I ask that you reflect for just a moment on the critical and so often unmet needs that developmentally disabled persons and their families have for professional psychological help. Think of the parents of a newborn who is disabled. Imagine the challenge facing a developmentally disabled young adult as he leaves the school system to go into the world of work. Consider the developmentally disabled adult who is moving from a large, perhaps remote, institution for a new life in the community, and focus for a moment on the family of an aging and too-often overlooked disabled adult who can live the remainder of his or her life outside of a nursing home.

In each of these cases, the key to success for a person with developmental disabilities is in his or her or their family's understanding and accepting and learning to manage their life situation. If parents are not able to see the potential of their disabled infant, if the young adult is able to cope with the stress of independent living, if the long-time institutionalized person is terrified of the challenge of the community, or if the aged developmentally disabled person feels life is not worth living, both they and we lose, because while human loss of a potential life unrecognized or unrealized is very apparent, so, too, is the real economic loss for all of us.

Institutionalization costs some $40,000 per year per client. Independence saves that cost and instead pays society the worth of a working contributing taxpayer.

This year, the Developmental Disabilities Act is before Congress for reauthorization. The American Psychological Association has presented testimony to both the House and Senate subcommittees urging that $6 million be authorized under the Developmental Disabilities Act demonstration projects for psychological services for developmentally disabled persons.

I urge you to consider the dividends this very modest amount will yield. In an appropriations act of over $100 billion, $6 million may seem like a very small amount, but to the persons with disabilities and their families who will receive necessary professional services, it can literally be the difference between dependence and independence.

PREPARED STATEMENT

Please remember the real life situations I have suggested to you this morning. They are the daily challenges of many persons who are developmentally disabled. They are challenges which can be met but not without help, which you can provide.

Thank you very much.

Senator WEICKER. Dr. Barclay, thank you very much.

[The statement follows:]

STATEMENT OF ALLAN BARCLAY

Mr. Chairman and members of the subcommittee, my name is Allan Barclay. I am associate dean for economic affairs and professor of professional psychology at Wright State University in Ohio. I am here today representing the American Psychological Association to urge you to include funds in the fiscal year 1988 appropriations bill for projects to demonstrate the effect of psychological services for persons with developmental disabilities and their families.

As our time is very limited, I ask that you reflect for just a moment on the critical and so often unmet need developmentally disabled persons and their families have for professional psychological help. Think of the parents of a newborn who is disabled; imagine the challenge facing a developmentally disabled young adult as he leaves the school system to enter the world of work; consider the developmentally disabled adult who is moving from a large, remote institution for a new life in the community and focus for a moment on the family of an aging—and too often overlooked—disabled adult who can live the remainder of his life outside of a nursing home.

In each of these cases the key to success for a person with disabilities in his or her and their family's understanding, accepting and learning to manage their life situation. If parents aren't able to see the potential of their disabled infant—if the young adult is able to cope with the stress of independent living, if the long-time institutionalized person is terrified of the challenge of the community or if the aged disabled person feels life is not worth living—both they and we lose.

Because while the human loss of a potential life unrecognized or unrealized is very apparent, so, too, is the real economic loss to all of us. Institutionalization costs some $40,000 per year or more per client. Independence saves that cost and instead pays society the worth of a working contributing taxpayer.

This year, the Developmental Disabilities Act is before Congress for reauthorization. The American Psychological Association has presented testimony to both the House and Senate subcommittees urging that $6 million be authorized under the Developmental Disabilities Act demonstration projects for psychological services for developmentally disabled persons. I urge you to consider the dividends this very modest amount will yield.

In an appropriations act of over $100 billion, $6 million may seem like a very small amount but to the persons with disabilities and their families who will receive necessary professional services, it can literally be the difference between dependence and independence.

Please remember the real life situations I have suggested to you this morning. They are the daily challenges of many persons who are developmentally disabled. They are challenges which can be met but not without help which you can provide.

Thank you.

STATEMENT OF EDMUND S. McLAUGHLIN, PRESIDENT, REHABILITATION CENTER OF EASTERN FAIRFIELD COUNTY, ON BEHALF OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Senator WEICKER. I call Edmund McLaughlin of the National Association of Rehabilitation Facilities.

During Mr. McLaughlin's testimony I will have to leave to go to the floor, since I am supposed to be there at 10. If Chairman Chiles is here, the hearing will continue. If he is not, the committee will stand in recess until such time as he does, which should be within a matter of a few minutes.

Ed, I just wanted to have the opportunity to personally greet and welcome you, and we look forward to your testimony.

Mr. McLAUGHLIN. Thank you very much, Senator. It is a pleasure to be here, as always, to talk with you and your committee and identify some of the concerns that we have regarding the rehabilitation field.

My name is Ed McLaughlin. I am here on behalf of the National Association of Rehabilitation Facilities. The national association is a national voluntary membership organization of community-based rehabilitation facilities with over 600 rehabilitation facilities and 23 affiliated State chapters.

These rehabilitation facilities serve approximately 700,000 people with disabilities annually. We are very pleased, obviously, to be here to make these comments.

I would like to just identify four particular areas of concern and capsulate them for your hearing. As to the vocational rehabilitation issues, the Vocational Rehabilitation Act of June 1973 remains the foundation, as you well know, having had so much to do with and played such a great part in having it continue, for vocational services to persons with disabilities.

NARF urges the subcommittee to increase funding for basic State grants to $1,409,000,000. This modest increase over current levels will allow more persons with disabilities to be served and ultimately save a tremendous amount of money.

Certainly a program that you support quite extensively is the program called supported employment, which has the potential of offering many severely disabled persons the opportunity to do meaningful work in community-based settings. Some $22 million is authorized for fiscal year 1987, but no money has been released to the States because regulations have not yet been proposed.

This subcommittee should appropriate the full $26.47 million authorization and not allow the administration's slowness in promulgating regulations to delay implementation of this program.

Under the Education for all Handicapped Children Act, there is a new authority for developing and implementing statewide systems of coordinated, comprehensive, multidisciplinary and interagency programs to provide early intervention, health and social services to handicapped children. I might add that in the State of Connecticut we also have a rather extensive program that you helped bring about.

The administration unfortunately has called this program premature. This is exactly the kind of program that will treat handicapped children with the services that can do the most good to prevent or substantially reduce the later adverse consequences of their disability. The program should be funded at its authorized level of $75 million.

As the medical rehabilitation issues, about 57 percent of the administration's spending reductions are targeted on Medicare service providers and would limit payments to providers, including rehabilitation. Medical rehabilitation providers have experienced considerable problems with the Medicare Program.

The National Association of Rehabilitation Facilities opposes continued reductions and payments to Medicare providers and reductions in the ability of Medicare contractors to administer the programs. For example, there are over 113 comprehensive outpatient rehabilitation facilities in the country. According to NARF's 1986 national survey, the payment time for claims in 1985 submitted by these organizations ran as long as 60 to sometimes well over 120 days, which obviously creates a problem in funding these programs and maintaining them.

We urge the committee to make adequate funds available for claims processing and payment and to continue to require the payment for outpatient rehabilitation providers be made promptly. The administration has requested just a little over $1 million for contractors, which is only slightly over the current Congressional Budget Office [CBO] baseline. We urge that funds for payment of processing hearings and reconsideration of denials be increased by $100 million over the amount requested.

As to training, which has become more and more a crisis, our members have reported that they are having trouble finding qualified personnel to serve persons with disabilities. Our facilities state that it is extremely difficult to find and attract qualified rehabilitation positions known as physiatrists, physical therapists, occupational therapists, speech and language pathologists, rehabilitation nurses, and other skilled therapists.

The administration is seeking to curtail funding for such personnel under the Public Health Services Act by phasing out the National Health Services Corps and reducing health professions and their educational funding by rescinding $135 million. We recommend that this request be increased to the appropriated amount and that the committee express its interest in having these funds focused on providing support to training programs for labor shortage areas for all allied health personnel and for health professions, indeed, in the educational programs as well.

Last, this subcommittee should fund rehabilitation training programs at the full authorization level of $33 million and direct RSA to consolidate all postemployment facilities and training programs into one category called regional facility continuing education programs. This would provide a single identifiable resource for the facilities within each region.

The National Institute of Disability Rehabilitation and Research indeed also deserves some consideration. They conduct research and demonstration projects and related activities which concern the rehabilitation of persons with disabilities, as well as identifying new forms of prosthetic devices which indeed make persons more functional.

Research is now being funded at more than 100 educational institutions and in various areas of interest, including spinal cord injury, arthritis, heart disease, mental illness, deafness, blindness, and head trauma.

The administration's fiscal budget 1988 request is for $48 million. This level of funding is the same as that requested for fiscal year 1987. We suggest, however, that the funding for NIDRR increase to $52 million for that fiscal year.

PREPARED STATEMENT

Mr. Chairman, wherever thou art, I thank you very much for the opportunity of talking to whoever I talked to. [Laughter.]

[The statement follows:]

STATEMENT OF EDMUND S. MCLAUGHLIN

Good morning Mr. Chairman. My name is Ed McLaughlin. I'm here on behalf of the National Association of Rehabilitation Facilities. NARF is the national voluntary membership organization of community-based rehabilitation facilities with over 600 rehabilitation facilities and 23 affiliated state chapters. These rehabilitation facilities serve well over 700,000 persons with disabilities annually. The membership includes freestanding rehabilitation hospitals, comprehensive outpatient rehabilitation facilities, developmental work centers and vocational facilities as well. We are very pleased to be able to testify before you today on issues of concern to us in the FY 1988 Labor-HHS Education Appropriations Bill.

Vocational Rehabilitation Issues

The Rehabilitation Act of 1973 remains the foundation for vocational services to persons with disabilities. The Administration has asked that the basic grants to the states be cut back to the 1986 level. This is incomprehensible for a program whose primary aim is to put disabled persons into competitive jobs in the community. NARF urges this Subcommittee to increase funding for basic state grants to $1409.1 million. This modest increase over current level will allow more persons with disabilities to be served and ultimately save a tremendous amount of money.

There is a new program called supported employment which has the potential of offering many severely disabled persons the opportunity to do meaningful work in community-based settings. $22.1 million is authorized for FY 1987, but no money has been released to the states because regulations have not yet been proposed. This Subcommittee should appropriate the full $26.47 million authorization and not allow the Administration's slowness in promulgating regulations to delay implementation of this program. Report language accompanying the appropriations should strongly suggest utilization of community-based rehabilitation facilities to carry out this program at the local level so that those federal dollars can be streched to their fullest.

Under the Education for All Handicapped Children Act, there is new authority for developing and implementing statewide systems of coordinated, comprehensive, multi-disciplinary inter-agency programs to provide early intervention health and social services to handicapped children, birth through age 2, and their families. The Administration called this program "premature". This is exactly the kind of program that will treat handicapped children when the services can do the most good to prevent or substantially reduce the later adverse consequences of their disability. The program should be funded at its authorized level of $75 million.

Medical Rehabilitation Issues

About 57% of the Administration's spending reductions are targeted on Medicare service providers and would limit payments to providers, including rehabilitation.

Medical rehabilitation providers have experienced considerable problems with the Medicare program. NARF opposes continued reductions in payments to Medicare providers and reductions in the ability of Medicare contractors to administer the program. The Omnibus Budget Reconciliation Act of 1986 included amendments to require Medicare contractors, (intermediaries and carriers) to pay clean claims within 30 days for fiscal year 87 and within 24 days by FY 1990. However, the manner by which claims are being handled defeats Congressional intent. For example, there are over 113 comprehensive outpatient rehabilitation facilities (CORFs) in the country. According to NARF's 1986 national survey the payment time for claims in 1985 submitted by these organizations ran as long as 60 to well over 120 days.

We urge the Committee (1) to make adequate funds available for claims processing and payment, and (2) to continue to require that payment for outpatient rehabilitation providers (CORFs) be made promptly. The Administration has requested just $1.162 million for contractors, which is only slightly over the current CBO baseline and is inadequate. We urge that funds for payment processing, hearings and reconsideration of denials be increased by $100 million over the amount request of $1.162 million.

Training

Our members have reported that they are having trouble finding qualified personnel to serve persons with disabilities. Our facilities state that it is extremely difficult to find and attract qualified rehabilitation physicians known as physiatrists, physical therapists, occupational therapists, speech language pathologists, rehabilitation nurses and other skilled therapists.

The Administration is seeking to curtail funding for such personnel under the Public Health Services Act by phasing out the National Health Services Corps and reducing health professions education funding by rescinding $135 million. We recommend that this request be increased to the appropriated amount and that the Committee express its interest in having these funds focused on providing support to training programs for labor shortage areas such as physiatry, physical therapy, occupational therapy, speech language pathology, and other allied health personnel, under NHSC, health professions education programs and the health education loan programs.

Facility administration programs currently funded by RSA are to upgrade the skills, knowledge, and practices of management and administrative personnel of rehabilitation facilities. RSA/OSERS funding assists facilities, independent living centers, and other community-based programs to participate in long and short term training activities. The demand for this type of training is critical due to implementation of federal initiatives and emerging community needs. Over the last several years, there has been an erosion of federal support in this training category.

In 1986, 1300 rehabilitaiton facilities were provided services through these facility administration training programs. In 1987, it is estimated that only 980 facilities can be served unless OSERS increases funding. Over 2000 facilities will be unable to participate in these important training programs due to the lack of funding.

This Subcommittee should fund rehabilitation training programs at the full authorization level of $33 million and direct RSA to consolidate all post-employment facilities training programs into one category called Regional Facility Continuing Education Programs. This would provide a single identifiable resource for facilities within each region.

National Institute of Disability, Rehabilitation and Research

The NIDRR conducts research and demonstration projects and related activities concerning rehabilitation of persons with disabilities. NIDRR supports research and training centers, rehabilitation engineering centers, research grants, fellowships and research demonstration projects. Research is now being funded at more than 100 educational institutions and in various areas of interest including spinal cord injury, arthritis, heart disease, mental illness, deafness, blindness, and head trauma.

The Administration's FY 1988 budget request is for $48.5 million. This level of funding is the same as that requested for FY 1987. The FY 1988 appropriations bill provided for funding of $52 million.

NARF strongly recommends that funding for NIDRR increase to $52 million for FY 1988.

Mr. Chairman, thank you for this opportunity to raise these issues before the Subcommittee. I will be glad to answer questions or provide any additional information you or your staff may need.

NARF RECOMMENDATIONS FOR FY 1988 APPROPRIATIONS
(in millions of dollars)

REHABILITATION ACT PROGRAMS	
State grants	$1409.1
Training	$33
Independent Living	$49.66
Special Demonstrations (inc. Supported Emp.)	$27.4
Projects With Industry	$17
Special Recreation	$2.4
Client Assistance	$7.5
Research (NIDRR)	$52
Supported Employment State Grant	$26.47
SPECIAL EDUCATION	
State and Local Grants	$2109.12
Pre-school incentive and intervention	$75
Transitional Programs	$7.7
DEVELOPMENTAL DISABILITIES	
State grants	$62.2
Protection and Advocacy	$25
University Affiliated Facilities	$14.76
Special Projects	$2.65
JOB TRAINING PARTNERSHIP ACT	
Title II	$1934
Pilots and Demonstrations	$40.7
NATIONAL COUNCIL ON THE HANDICAPPED	$.93
TITLE XX BLOCK GRANT	$3500

Senator CHILES [presiding]. Thank you. Thank you for your testimony.

We are going to take just a second before we take our next witness, and I will be right back.

[A brief recess was taken.]

STATEMENT OF HELEN BLANK, DIRECTOR, CHILD CARE DIVISION, CHILDREN'S DEFENSE FUND

Senator CHILES. Our next witness will be Helen Blank with the Children's Defense Fund.

Good morning.

Ms. BLANK. Good morning. Senator Chiles, on behalf of Marian Adelman and all of us at CDF, we would like to extend our sincere appreciation to you and members of the subcommittee for your longstanding support for children's programs. We are especially grateful for the kind of support that is provided. We know you have had a very tough job in the budget, and we feel that you have taken some important steps. As the director of child care and responsible for Head Start, we are extremely pleased to see the recognition that Head Start has gotten.

Obviously, your leadership has been critical to the growing congressional support for meeting the needs of our children as well as the reservoir of public support that is growing for children. It is key, and I think that you all recognize that we have to have increased investments for children.

America's future strength, our competitiveness, our continuing prosperity depend in large part on the development of today's children into productive adults. Despite valiant efforts of this subcommittee, we still have too many children in poor health and who are undereducated and untrained and we are afraid they will not be able to meet the challenges of the 21st century.

We would urge this subcommittee to begin a series of target investments in our children. We ask you this year to look at several key programs. The first is Head Start. When Senator Weicker was here, my friend, Eugenia Boggus, a parent who is president of the Head Start Association, spoke eloquently about the success of Head Start affecting her own life and the effect on countless children and families over the last 20 years, so I am not going to repeat, even though Head Start is one of my favorite programs.

You all well know what Head Start can do in terms of increasing the future opportunities for children and families, and we would urge you to fund it at its full authorization level this year. You do not have a major child care program to invest resources in. We hope to remedy that. There is a large coalition in Alliance for Better Child Care [ABC] that is working on new Federal solutions to helping fill our enormous child care gaps. We will be talking to Members of Congress about ABC's initiative in the near future.

For now, there are a few small child care programs that we would urge you to begin investing in, and the first is $10 million for the School Age Resource and Referral Program. $10 million for a new program that was authorized in the Higher Education Act that would help low-income mothers who have very little access to child care support if they are in school get child care assistance while they are in institutions of higher learning;

A small amount $1½ million, but an important amount, to provide scholarships to caregivers seeking to improve their skills by early child development associate scholarships; and $5 million each for respite care and child care for children in crisis nurseries.

For chapter I, another key program tied to our competitiveness and our future, we would recommend a fiscal year 1988 funding level of $4.44 billion. Obviously, strong basic skills are key to participation in our work force and economy. Youths who by the age of 18 have the weakest reading and math skills when compared to those with above average basic skills are four times more likely to turn to public assistance, four times more likely to be out of work and out of school, seven times more likely to drop out of school before graduation, and eight times more likely to bear children out of wedlock.

We urge you to look at the other education programs listed in our testimony.

For maternal and child health, we urge a fiscal year 1988 appropriation of $557 million. You are aware this is a cost effective program. We need more funds to reach more low-income pregnant women with prenatal services, additional infants with genetic disease screening, particularly critical for sickle cell and other genetic diseases, and more children with special primary care and case management services.

Given the large number ofchildren who are not immunized, we would also recommend $110 million for an immunization grant program, $550 million for community and migrant health centers, and $159 million for a family planning program.

We urge you to look at our testimony in terms of our recommendations for Job Corps and Summer Youth Programs. Both programs reach a very small percentage of eligible youth and can make a large difference to teens who for the most part remain unserved by programs.

Child Welfare Services is a program we have always been critically concerned about. We recommend it be funded at $266 million. Despite increased reports of child abuse and neglect, what we have seen is a decrease in funds targeted to these important programs and a decrease in funds targeted to help keep families together and reunite them.

We know that we must invest now for children who are victims of child abuse, neglect, have emotional disturbances, or runaways. We will only exacerbate those problems and have to invest a great deal more later.

We list a number of programs related to child welfare in the testimony, including $45 million for the independent living initiative, and hope that these, too, can be funded because often these children are really most vulnerable.

That was a rather long list. I am sorry I talked past the red light.

PREPARED STATEMENT

Senator CHILES. Thank you, ma'am.

Ms. BLANK. Thank you, Senator Chiles.

[The statement follows:]

STATEMENT OF HELEN BLANK

On behalf of Marian Edelman and the staff of the Children's Defense Fund, I would like to extend sincere appreciation to the Chairman and Members of the Subcommittee for your long-standing commitment to federal programs for children and families. Your outstanding leadership has been critical to growing Congressional support for meeting the health, education and developmental needs of our children, as well as to the growing reservoir of public support for additional spending for children and youth.

Increased investments in our children and youth are absolutely essential if we are to maintain our nation's position of world leadership. For America's future strength, true national security, international competitiveness as well as its continuing prosperity depend in large part upon the development of today's children and youth into tomorrow's healthy, productive, trained and self-sufficient adults. Despite the valiant efforts of this Subcommittee, our next generation remains disproportionately poor, undereducated, untrained and generally ill-prepared for the challenges of the 21st century.

We can no more afford to write off a significant portion of our next generation than we can afford the debilitating and costly consequences of their neglect. Illiteracy, school drop-outs, unemployment, and infant mortality severly limit our nation's potential and cost us dearly as well. It is now more important than ever to pursue prudent spending policies that invest in successful preventive and cost-effective programs for children and youth.

We urge this Subcommittee to mount a carefully conceived, comprehensive strategy of investments directed toward ensuring that all children have the basic health, nutrition, and early childhood services as well as the strong academic and job preparation skills on which our future productivity and prosperity depend. We urge you to begin in 1988 by placing funding priority in the following children's programs:

Head Start: We urge you to invest $1.263 billion in the Head Start program in FY 1988. This $132 million increase above the 1987 appropriation would bring the program to its authorization level.

Head Start is among our most effective programs for young children, and enjoys widespread support nationally and in communities all across the country. Currently serving 451,000 children, it is the single federal program offering a comprehensive preschool experience to disadvantaged youngsters.

Head Start works and works well. Study after study indicate that participation in comprehensive preschool programs, such as Head Start, reduces the high school drop-out rate, increases college attendance rates, increases employment and reduces welfare and crime rates. Yet despite such critical and well-known outcomes, more than 80 percent of the disadvantaged preschoolers eligible for Head Start are denied access to it for lack of resources. It defies rationality to limit Head Start spending to only $1.131 billion while, according to a recent study, the nation is losing a staggering $228 billion in lifetime earnings, and $68 billion in tax revenues simply due to the dropouts from the high school class of 1981.

We urge you to appropriate $1.263 billion for Head Start in FY 1988, and the following amounts for other important child care programs: (1) $10 million for the School Age Child Care and Resource and Referral program; (2) $10 million for the newly authorized Special Child Care Services for Disadvantaged College Students program; and (3) $1.5 million for the Child Development Associate Scholarship program.

Chapter I: We recommend a FY 1988 funding level of $4.444 billion (an increase of $500 million) for the Chapter I, Education of the Disadvantaged program. This is a similarly cost-effective, preventive effort repeatedly shown to raise the basic reading and mathemetic skills of its participants.

Strong basic skills are increasingly essential to participation in our workforce and economy. The level of a child's basic skills has a powerful effect on his or her prospects for future achievement or failure, eventual self-sufficiency or dependency. By the time youths have reached the end of their teenage years, poor basic academic skills sharply increase the likelihood that they will face a diverse range of problems - costly to them and to the nation. Youths, who by the age of 18 have the weakest reading and math skills when compared to those with above average basic skills, are:

- o 4 times more likely to turn to public assistance
- o 4 times more likely to be both out of work and out of school
- o 7 times more likely to drop out of school before graduation; and
- o 8 times more likely to bear children out of wedlock.

Despite the importance of strong basic skills and Chapter I's proven success in raising such skills, almost half of those eligible for and in need of Chapter I services are denied assistance.

All educationally disadvantaged children must be provided Chapter I services, and we applaud the growing support in Congress to reach that goal. We urge your Subcommittee to lead this effort by adding $500 million to Chapter I in FY 1988. Equal increases in each of the next five years would provide full funding for Chapter I, raise the basic skills of our children, and greatly contribute to our international competitiveness.

Many other federal education programs are also critical to our children and our future. We also urge the Subcommittee to appropriate funds for any newly authorized drop-out prevention programs as well as (1) $15 million for the newly authorized University and High School Partnership Program; (2) $250 million for Bilingual Education; (3) $150 million for the Magnet Schools program; (4) $2.019 billion for the Handicapped Education state and local grants, $216 million for preschool grants, and $75 million for infants; and (5) $4.6 billion for Pell grants.

Maternal and Child Health Block Grant: We urge a FY 1988 appropriation of $557 milion for MCH, in addition to a FY 1987 supplemental increase of $75 million - funding consistent with the reauthorization enacted late last year.

The Maternal and Child Health Block Grant is a cost-effective program important in reducing and preventing infant mortality. The additional funds requested for FY 1988 are needed to reach (1) greater numbers of low income pregnant women with prenatal services that effectively reduce the number of low birthweight babies as well as infant and neonatal deaths; (2) additional infants with genetic disease screening, particularly critical for sickle-cell and other genetic diseases and; (3) more children with special primary care and case management services.

Despite the universally recognized need to reduce infant mortality and the proven effectiveness of prenatal and pediatric care, national maternal and child health indicators continue to erode. We have had a shameful and dramatic drop in our infant mortality rate from our sixth ranking in 1950-1955 to our current tie for the last place among the 20 industrialized nations.

Increased funding for MCH and other federal health programs will save precious lives and scarce public resources. We recommend a FY 1988 appropriation of $110 million for the Immunization Grant program. While every dollar invested in immunizations can save up to $10 in unnecessary health care costs, approximately 35 to 40 percent of preschool children are inadequately immunized against measles, rubella, diptheria, tetanus, or pertusis. We also recommend an FY 1988 appropriation of $550 million for Community and Migrant Health Centers, and $159 million for the Family Planning program.

Job Corps and Summer Youth: We recommend a FY 1988 funding level of $800 million for the Job Corps and $950 million for the Summer Youth Employment and Training program. Such increased appropriations are consistent with authorization levels, and represent important efforts to enhance the skills of our workforce and the competitiveness of our economy.

The Job Corps program has been extremely effective in providing the basic education, vocational training and support services needed by highly disadvantaged youths to increase their rates of school completion, employment and earnings. The Job Corps serves less than 3 percent of the 1.4 million poor teens officially counted as unemployed. A $144 million increase would provide training to an additional 20,000 disadvantaged youths. A $200 million FY 1988 increase for the Summer Youth program would give local communities the resources they need to mount effective remedial education programs while also providing important work experience to additional disadvantaged teens.

Child Welfare Services: We recommend a FY 1988 appropriation of $266 million for the Child Welfare Services program, a $43.5 million increase to bring the program to its authorized level.

Increased funding for the Child Welfare Services program is essential to help states respond to increasing reports of child abuse and neglect, and to preserve and reunite families whenever possible. Despite strong official concern for the protection of children against abuse and neglect, programs to assist them have been vastly underfunded at the same time that reports of child abuse have escalated dramatically. An estimated 1.9 million children were reported abused in 1985 (the most recent data) - a 58 percent increase since 1981.

Child abuse, neglect, emotional disturbance, running away, and other special problems of children in troubled families can be prevented and treated. Ignoring these problems risks even more serious and costly harm. The issue is not whether to help these children, but when and how.

We urge the Subcommittee to provide an additional $160 million in FY 1988 to bring these programs to the following levels: (1) $266 million for the Child Welfare Services program; (2) $45 million for the Independent Living initiative that is part of the Title IV-E Foster Care program; (3) $50 million for the Child Abuse Prevention and Treatment program; (4) $26 million for the Family Violence Prevention and Services Progam; (5) $50 million for the Runaway and Homeless Youth Program; and (6) $10 million for the Child and Adolesecent Services System component of the Community Support Program.

STATEMENT OF ALFRED R. GLANCY III, CHAIRMAN, MICHIGAN CONSOLIDATED GAS CO.

Senator CHILES. Now we will hear from Mr. Alfred F. Glancy, the chairman of Michigan Consolidated Gas Co.

Mr. GLANCY. Mr. Chairman, I am Al Glancy, chairman and chief executive officer of Michigan Consolidated Gas Co., in Detroit. Thank you for the opportunity to testify on behalf of MichCon's customers with respect to the Low-Income Home Energy Assistance Program [LIHEAP]. MichCon is a gas distribution company serving over 1 million customers in Michigan, including Detroit.

One hundred sixty-five thousand of MichCon's customers are low-income people dependent on LIHEAP for assistance in paying their bills. In fact, the Michigan Department of Social Services is our largest single customer.

Michigan has a comprehensive and efficient energy assurance program in which State-generated revenue dollars are combined with LIHEAP funds to see that all of the State's low-income customers have the opportunity to receive energy and weatherization assistance and, most importantly, protection against fuel shutoffs.

Energy assurance is dependent on adequate LIHEAP funding. We believe LIHEAP should be funded at the congressionally authorized level of $2.1 billion, a modest increase over fiscal year 1987 but virtually identical to fiscal year 1985.

In setting the amount for fiscal year 1987, the conference report on the appropriations bill stated:

> The conferees wish to make it clear that the amount agreed to for LIHEAP should not be construed as a decline either in support for the program or in the need for such assistance. Rather, it is reflective of the unusual circumstances which exist this year, lower energy prices in general and the availability of the oil overcharge funds in the States.

Conditions have changed since last year. Forecasts are for increased wellhead gas costs of about 8 percent next winter, and the vast bulk of the oil overcharge funds has already been allocated to the States. LIHEAP recipients are truly needy. With average incomes of slightly over $6,000, about 15 percent of their income is required for energy, four times the proportion for the average American household.

PREPARED STATEMENT

LIHEAP funds benefit all utility customers by holding down uncollectables and subsequently general gas rates. We therefore believe that LIHEAP is an important and vitally necessary program that is efficiently run and serves an important national purpose and that funding, as I stated, should be restored to the $2.1 billion level.

Thank you very much.

Senator CHILES. Thank you, sir.

[The statement follows:]

STATEMENT OF ALFRED R. GLANCY III

Mr. Chairman and members of the Subcommittee. I am Alfred R. Glancy, III, Chairman of Michigan Consolidated Gas Company (MichCon) in Detroit.

Thank you for giving me the opportunity to testify on behalf of MichCon with respect to the Low Income Home Energy Assistance Program (LIHEAP).

MichCon is a gas distribution company which serves about one million customers in Michigan, including the City of Detroit. Tens of thousands of our customers are low income people who depend on LIHEAP funds for assistance in paying their fuel bills

Michigan has a strong, comprehensive and efficient Energy Assurance Program which provides assistance to senior citizens, the working poor and welfare recipients. In Michigan, LIHEAP funds are combined with state general revenue dollars to make the Energy Assurance Program work. The state's utility companies, the Michigan Public Service Commission and local community action agencies work closely together to see that all of the state's low income households have the opportunity to receive energy audits, weatherization assistance where necessary, ongoing help in paying high fuel bills, energy crisis assistance and, most importantly, guarantees against fuel shut-offs.

Since its implementation in 1984, the Energy Assurance Program has successfully met its goals of significantly reducing utility uncollectibles and low-income customer shut-offs, while reducing administrative costs and inefficiencies in providing energy and conservation assistance to low-income households. Each year we continue to improve it and we believe that Michigan's Energy Assurance Program is a useful model for other states to follow. Its operation, however, is dependent on adequate LIHEAP funding. Without that funding, the effectiveness of Michigan's Energy Assurance Program would be drastically reduced. We believe that LIHEAP should be funded at the Congressionally-authorized level of $2.132 billion for FY 1988. We understand that $2.132 billion would be a modest increase in funding over the amount made available in FY 1987; however, it is virtually identical to 1985 funding levels.

In FY 1985, Congress appropriated $2.1 billion for LIHEAP. In FY 1986, the appropriation was reduced to $2.009 billion as a result of the 4.3% across the board Gramm-Rudman reduction. In FY 1987, Congress further reduced the funding for the program to a level of $1.825 billion.

However, in setting the funding level for LIHEAP at $1.825 billion for FY 1987, the Conference Report on the Appropriations bill stated:

> "The conferees wish to make clear that the amount agreed to for LIHEAP should not be construed as a decline either in support for the program or in the need for such assistance. Rather it is reflective of the unusual circumstances which exist this year: lower energy prices in general and the availability of oil overcharge funds to the states."

The conditions referred to in that report no longer hold true. For FY 1988, we do not anticipate reductions in the prices for MichCon-distributed gas or in national average residential energy prices. On the contrary, for example, our major gas supplier, ANR Pipeline Co. just filed a purchased gas adjustment with FERC which will increase rates we pay them effective May 1. In addition, at a recent conference in Houston, Scott Jones, Vice President for Energy Utilities at

Chase Econometrics, forecasted an increase of 8% in average wellhead gas prices by year-end.

We also do not anticipate that there will be substantial additional amounts of oil overcharge funds allocated to the states in FY 1988. The vast bulk of oil overcharge funds have already been allocated to the states. In 1987, Michigan received some $70 million in Exxon overcharge funds from which the state allocated $38.6 million for low income energy assistance and $13 million for low income weatherization assistance. We don't expect anything close to that amount in 1988.

We see, therefore, a need for Congress to restore LIHEAP funding to the previous funding level of $2.1 billion per year. We know that Congress faces tough fiscal decisions and that this Subcommittee has a difficult job in making adequate provisions for many important and necessary programs.

We believe, however, that LIHEAP should have a special claim on your attention. We know from our own experience and from looking at national statistics that LIHEAP-assisted households are truly needy. In 1984, for example, these households had an average income of $6,184, versus a national average household income of over $25,000. LIHEAP-assisted households typically spend about 15% of their income on energy, about four times the percentage that the average American household spends for that purpose.

It is also important to point out that LIHEAP funds benefit _all_ utility customers, because in the absence of such funds, the amount of unpaid bills will rise and other utility customers will eventually be faced with the resulting uncollectible expenses reflected in their rates.

We are most appreciative that you have taken the time to hear our view on this important matter. We urge you to look carefully at the need for adequate LIHEAP funding. We believe that when you do, you will see that LIHEAP is an important and vitally necessary program that is efficiently run and that serves an important national purpose. Thank you.

STATEMENT OF DONALD H. WEDEWER, DIRECTOR, FLORIDA SERVICES FOR THE BLIND AND VISUALLY HANDICAPPED, COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

Senator CHILES. Now we will hear from Mr. Donald W. Wedewer, director of Florida Services for the Blind and Visually Handicapped.

Mr. WEDEWER. Good morning, Senator Chiles.

Senator CHILES. Good morning.

Mr. WEDEWER. It is good to be here with you again. A few asides before I get into my testimony. I serve on the foundation, board of trustees and one of the members is Governor Dan Walker of Illinois, former Governor, who wants me to say hello to you and be remembered to you.

Senator CHILES. Yes, sir.

Mr. WEDEWER. He spends part of his time in Florida and part in Illinois.

Senator Chiles, it is indeed a pleasure to be here to represent the Council of State Administrators for Vocational Rehabilitation. As you know, every State has programs for vocational rehabilitation, both general and blind, and the territories and the District of Columbia also have agencies. It is a partnership between the Federal Government and the State governments. I represent, of course, the Florida Division of Blind Services, one of those units of the Florida Department of Education.

First, I would like to say that we appreciate the tremendous support that Congress has given through the years to this partnership program that started 66 years ago after World War I and has served our handicapped people so well in all that time. Certainly it has been a marvelous program which enables many disabled persons to achieve a life of independence and dignity. For that, we appreciate the tremendous efforts of Congress.

I personally want to thank you, Senator Chiles, for your recent acceptance as the chairman of the Budget Committee here in the Senate of a larger assumption for people programs that are so needed in our country. We want to thank you for that. We know it is a tremendous burden for you to keep the budget in line and for you to accept those kinds of increases. We certainly are thankful for it.

Rehabilitation in 1986, the last year we had statistics, served over 923,774 handicapped persons. Of that, we rehabilitated, that is, put back in the work force in competitive employment, 223,354 people. That is a significant number. The dollars that have been available, however, actually allow us to serve 1 in 20. As a recent Lou Harris poll showed, we actually have the largest number of unemployed persons; that is, in the area of handicapped persons, we have the largest number of unemployed in the United States. So we need to increase our efforts, not decrease them.

On behalf of the States, our States have been great in their support of these programs and in almost every case overmatches the Federal allotment so that more people can be served.

In addition, I want you to know, Senator Chiles, that we are conscious of the importance of every dollar. So as State directors, we utilize every similar benefit available before we spend our hard dollars of Federal and State money, so that we make sure private insurance money is used, tnat the Pell grants are taken advantage of, that Medicare, Medicaid, and all the rest of those programs that have dollars for certain purposes are spent before we release our hard-earned tax money to help these recipients that we serve become taxpayers.

That is why we concentrate on the two words, rehabilitation pay. For every dollar spent, $10 is returned by the rehabilitated disabled person to the Federal dollars, and that is important.

It means, therefore, that it is good business to spend dollars. Rehabilitation stays. People who are once rehabilitated become taxpayers for the rest of their lives and, of course, live better lives in doing so.

Now, the Rehabilitation Act and the authorization, which is a marvelous piece of legislation, has certain authorized amounts, and we believe that the Senate and Congress should fund the total of $1,409,100,000 for the basic program of State partnership and include all the dollars for those things that are part of it, such as independent living, which has become such a significant part in addressing all the needs of handicapped persons and all the other parts of it that fit into this marvelous legislation, such as research and training.

That is important, too, and we know it. We would like to see all phases of it funded as authorized under this great Rehabilitation Act of 1973, which is statute Public Law 93–112 as amended.

PREPARED STATEMENT

Senator CHILES. Thank you, sir. We will see if we can be helpful in those regards.

Mr. WEDEWER. Thank you very much.

Senator CHILES. We appreciate your testimony here.

[The statement follows:]

STATEMENT OF DONALD H. WEDEWER

The Council of State Administrators of Vocational Rehabilitation is comprised of the chief administrators of the public rehabilitation agencies providing services to persons with disabilities in the fifty states, the District of Columbia, and our Nation's territories.

These agencies constitute the state partners in the State-Federal Program of Rehabilitation Services for persons with mental and/or physical disabilities, as authorized by the Rehabilitation Act of 1973, P.L. 93-112, as amended. This 66-year-old program is the major resource for, and the State Rehabilitation Agencies are the primary providers of, rehabilitation services to our Nation's citizens with disabilities.

The Rehabilitation Act is recognized as the most complete and well-balanced legislation in the human services field.

The primary focus of the Act is to provide services to persons with mental and/or physical disabilities, enabling them to re-enter the workforce or obtain employment for the first time, and to become independent of public assistance, publicly-funded health care, or family support. The provision of these services results in a direct savings to government, as competitive work generates increased tax revenue, and as decreased dependence saves public assistance and other expenditures.

In the Rehabilitation Act, provisions are included for (1) a comprehensive and individually-tailored program of Vocational Rehabilitation services to physically and/or mentally handicapped individuals; (2) an innovation and expansion program; (3) a training program; (4) a research program; (5) a special projects program; (6) a rehabilitation facilities program; (7) a comprehensive services program for independent living; and (8) a supported employment program.

VOCATIONAL REHABILITATION SERVICES: BASIC STATE GRANTS

Section 110

FY 1988 CSAVR RECOMMENDATION........$1,409,100,000
FY 1988 AUTHORIZATION...............$1,409,100,000

Basic State Grants are the lifeblood of the Vocational Rehabilitation Program. This section of the Act funds the provision of vocational rehabilitation services to eligible individuals with mental and physical disabilities.

These Federal dollars, matched with state money at a ratio of 80% to 20%, permit State Rehabilitation Agencies to provide, or contract with private organizations and agencies to provide, individualized, comprehensive services to persons with physical disabilities, for the purpose of rendering these individuals employed and independent.

Such services may include evaluation; comprehensive diagnostic services; counseling; physical restoration; rehabilitation engineering; prosthetic devices; various kinds of training and training supplies; placement; tools and equipment; transportation; post-employment services; and any other service needed to rehabilitate an individual into employment.

For Fiscal Year 1986, the $1,145.1 million appropriated for Vocational Rehabilitation Services served 923,774 disabled individuals. Over 223,354 persons were rehabilitated into employment.

Despite this expenditure, there still are not sufficient funds to serve all those eligible, disabled people who have the potential and desire to work and who need rehabilitation services to obtain employment and self-sufficiency.

Alarmingly enough, best estimates are that Agencies are able to serve only one out of every twenty people who are eligible, due to a shortage of resources.

In addition, a Lou Harris Poll commissioned by the National Council on the Handicapped recently determined that over two-thirds of persons with disabilities, ages 16 - 64 are unemployed -- the highest percentage of any segment of our society.

State Rehabilitation Agencies, in carrying out the mandate of the Act to give priority of service to the rehabilitation of persons who are severely disabled, find that the costs, in time, effort and money, of serving this group are great -- much greater than the cost of rehabilitating the less severely disabled. This causes the Program to serve fewer people, while expending more money for adequate services, adequately-trained staff, adequate equipment, and adequate facilities.

In Fiscal Year 1986, 63 percent of all individuals served by State Rehabilitation Agencies were classified as "severely disabled" -- this is the highest percentage of persons with severe disabilities served in the history of the Program.

Unfortunately, the ability of the State Rehabilitation Agencies to provide necessary services is being impeded, due to limited resources and the costliness of serving persons identified as severely disabled (over 50 percent more costly than those to persons who are not severely disabled).

With these statistics in mind, and ever cognizant of the vast need for services, the Council strongly urges that the Congress provide appropriations for Basic State Vocational Rehabilitation Services in the amount of $1,409.1 million for Fiscal Year 1988.

It is important to remember that the justification for higher funding levels stems from the purpose for which the money is spent--the prevention of an incalculable waste of human potential--a purpose on which no price tag can be placed.

Appropriating additional monies for Vocational Rehabilitation Services reduces the Federal Deficit.

Over the decades, Vocational Rehabilitation has more than paid for itself by helping persons with disabilities increase their earning capacity; by freeing family members to work; and/or by decreasing the amount of welfare payments, health services, and social services they might need; as well as by assisting them to become taxpayers.

The Congressional Budget Office has stated that "a reduction of funds for rehabilitation ... would generate increases in other parts of the federal and state budgets."

There is a return to Federal and state treasuries of ten dollars for every dollar spent for Rehabilitation Services, according to the Rehabilitation Services Administration of the Department of Education.

Funds appropriated for Vocational Rehabilitation are a sound investment of the Public's money.

OTHER PROGRAMS UNDER THE REHABILITATION ACT

While the CSAVR's statement focuses on the major service delivery component of the Rehabilitation Act -- Basic State Rehabilitation Services -- the CSAVR supports adequate funding for all Sections of the Act, and wholeheartedly joins with the recommendations and rationale provided this Panel by other Organizations and Indiviudals.

These call for FY 1988 funding at the full authorization level for Rehabilitation Training and Research; Comprehensive State Independent Living Services; Independent Living Centers; Independent Living for Older Blind Individuals; Supported Employment State Grants; and for the other Service Programs and Demonstration Projects authorized by the Rehabilitation Act.

STATEMENT OF KINGSLEY ROSS, EXECUTIVE DIRECTOR, ASSOCIATION FOR RETARDED CITIZENS/FLORIDA AND MEMBER, GOVERNMENT AFFAIRS COMMITTEE, ASSOCIATION FOR RETARDED CITIZENS—UNITED STATES

Senator CHILES. Next, we will hear from Mr. Kingsley Ross, Association for Retarded Citizens of the United States.

Mr. ROSS. Senator Chiles, thank you very much. I am here to speak on two issues of particular importance to our association. The first issue is the Education of the Handicapped Amendments of 1986, and the second issue is the Rehabilitation Act Amendments of 1986. I will try to relate those to Florida in particular so you can understand the impact on our State as well as the Nation.

The education amendments authorize new programs for the handicapped, particularly for infants and toddlers to the age of 3. As you know, you were at the parent-to-parent conference a few weeks ago in Tampa, and that is particularly important to those parents because those are young parents.

They are looking at the future of their children. It helps the parents keep their children at home with them, which is very critical to us as a State and to us as a nation because it prevents institutionalization and allows those people to become more independent than they would otherwise.

We need $75 million to have that program fully funded this coming fiscal year, and that is a program which is very important to us.

The second program, the Rehabilitation Act Amendments, we would like to concentrate on the supportive work aspects. This affects adults. One thing that is very unique about Florida is we are an impact State. As you know, we export retirement services by importing people. When we do that, many of the people who are moving to Florida, in fact, 13 a day, are bringing their adult handicapped children with them.

This program allows these adult handicapped individuals to get into gainful employment, competitive employment, ironclad employment so they can earn a minimum wage and become productive, independent individuals and no longer have the need to stay with their parents either in terms of the economic dependency or in terms of the residential dependency, which, as you know, the aging population of Florida is very concerned about. What happens when their own life becomes infirm and they pass away? What happens to their children?

So the supportive work program becomes very important to us because that program allows individuals to become independent and no longer dependent on their parents or the State on an institutional basis because it allows them to get into competitive work.

We need $26,500,000 to fully authorize that program in this coming fiscal year.

The Florida program and the Nation as a whole is actually seeing an impact from people moving out of public schools and into an adult situation which they have never seen before. Florida has 6,200 people who are waiting for services now. Both the education amendments and the amendments to the Rehabilitation Act will help impact on those individuals and give them a chance that they might otherwise not have.

Thank you.

PREPARED STATEMENT

Senator CHILES. Thank you very much. Sixty-two hundred people?

Mr. ROSS. That is correct.

[The statement follows:]

STATEMENT OF KINGSLEY ROSS

Mr. Chairman, it is a pleasure and an honor to appear before you today on behalf of the Association for Retarded Citizens (ARC), an organization of 160,000 members throughout the United States, most of them parents of citizens with mental retardation, dedicated to the continuing task of improving the quality of life of persons with mental retardation.

The ARC is most keenly aware of the vital role you have played in literally saving our precious programs from huge reductions and terminations proposed by the current Administration. We thank you for your diligence and your unbending advocacy on behalf of our nation's citizens with mental retardation and other disabilities.

In regards to the FY 1988 appropriations for programs most critical to persons with mental retardation, we can simply say keep up your outstanding efforts. Last year the Congress enacted two laws which, when fully funded and implemented, will drastically reduce the dependency of many children and adults with mental retardation on costly future services and benefits and turn them instead into productive members of our society. These two laws are the Education of the Handicapped Amendments and the Rehabilitation Act Amendments of 1986.

In the area of special education, the Congress has restructured the federal government's role in funding preschool education for 3 to 5 year olds with handicaps, creating a mandate for all such children to be served by school year 1990-1991. It is vital that the Congress fully fund the Preschool Program under EHA at the fully authorized amount as it has done this year. An appropriation of $216 million is needed to fully fund the program. If the Congress does not fully fund this program, many eligible children will not gain access to needed educational services since the law delays the mandate for 1 year to the 1991-1992 school year. For many of us, waiting another year for something may not be critical, but for the 3 year old youngster with handicaps, such a delay is crucial and the opportunity for rapid development is lost forever.

In the same law, the Congress also authorized a totally new, very exciting program to serve infants and toddlers with disabilities or at risk of being disabled from the time they are born until they reach 3 years old. This Early Intervention Program holds fantastic promise, supported by much new research data, to maximize each child's developmental progress and again, significantly reduce the need for future services throughout life. Further, this program is aimed at helping the parents of these newborns to understand and cope with their infant born with disabilities. Full funding of this program at $75 million for FY 1988 is expected to spur all states to participate in the Early Intervention Program. Conversely, some states are not likely to enter this optional program if they see the Congress not meeting their fiscal promise.

Turning your attention to adults with disabilities, the Rehabilitation Act has authorized a new state grant program called Supported Employment. This program would assist individuals with severe handicaps, many of them mentally retarded, to enter the world of work in a competitive environment with the necessary support services. Supported Employment, while a relatively new concept in employment, has proven very successful in employing persons with severe mental retardation. Without supports such as job coaches, these individuals would likely never have the opportunity to enter the work force and become productive, tax paying members of our society. This modest program should be fully funded at $26.5 million, which represents a very small increase over current funding.

In regards to the other priority programs of importance to citizens with mental retardation and their families, we call your attention to the Education for the Handicapped State Grant and Vocational Rehabilitation State Grant programs. These two programs, administered by the Department of Education, play vital roles in educating and training our citizenry with handicaps. More than 750,000 school age children with mental retardation profit each year from special education in our nation's schools. Since educating children with handicaps is expensive, we recognize the major role the federal government plays through P.L. 94-142 funding in assisting local school systems. Although the Congress promised the schools a 40% reimbursement when it enacted the landmark special education law, schools are now receiving only a 10% reimbursement. We recommend the Congress fund this program at the 15% level as soon as possible. At the very minimum, federal support for special education should return to the 12% level that existed in FY 1980 by providing an appropriation of $1.7 billion.

Approximately 40,000 persons with mental retardation are successfully rehabilitated each year by the Vocational Rehabilitation State Grant Program. Despite this very impressive statistic, thousands of individuals who are mentally retarded are denied access to vocational rehabilitation services annually, not because they cannot be trained to work but simply because there are insufficient funds. The alternative to a trained, employable individual with mental retardation is a dependent, frustrated individual who must survive on costly benefits such as Supplemental Security Income (SSI) or other welfare type benefits. The ARC strongly urges the Congress to increase the State Vocational Rehabilitation funding to serve the many individuals with mental retardation and other handicaps who are waiting to be trained. We recommend an appropriation of $1.4 billion for this program.

Mr. Chairman, since the needs of persons with mental retardation are lifelong, many other federal programs that I do not have the time to review today also need your attention and support. Very important are funding increases for the Maternal and Child Health Block Grant, the Title XX Social Services Block Grant and the programs within the Developmental Disabilities Act. We have attached a chart of the many other federal programs which impact on the lives of children and adults with mental retardation and their families. We sincerely hope the Congress sees fit to fund these programs at the recommended amounts. Again, Mr. Chairman, we thank you and members of this Subcommittee for your strong support in the past and we hope you will again allow our programs to expand.

STATEMENT OF ROGER P. KINGSLEY, PH.D., DIRECTOR, CONGRESSIONAL RELATIONS DIVISION, GOVERNMENT AFFAIRS DEPARTMENT, AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Senator CHILES. Mr. Roger Kingsley, American Speech-Language-Hearing Association.

Dr. KINGSLEY. Mr. Chairman, I am pleased to have this opportunity, and I would like to just highlight two areas of special concern.

We all know how important Public Law 94–142 and the discretionary programs of the act are. What we find perplexing is how this administration can year after year place such a low value on these and other human service programs. Most disturbing is the Department's recommendation to eliminate funding for the early childhood intervention program and to drastically reduce funding for the preschool grant program.

I have here a letter that was sent by the Assistant Secretary of Legislation in the Department following the President's signing of the new law. It emphasizes the administration's support for the program and says, in part, providing services to these children before they reach school age can result in greater educational achievement and can reduce their dependence on others as they grow older. These children are specially deserving of our assistance so they may reach their fullest potential.

I agree with this statement completely. Unfortunately, the budget requests are in complete contradiction to this statement.

Among preschool age children with disabilities, the majority have primary handicaps of speech or language impairment, and many other children with disabilities have secondary disorders of communication. The early childhood and preschool grant programs will assist the States in providing services that these and other children with disabilities need and deserve. Therefore, we recommend full funding for these programs as authorized under Public Law 99–457.

The second is special education personnel development, a program that provides the human resources to carry out the basic State grant programs. Two changes brought about by Public Law 99–457 make it imperative that this program receive full funding. First is the expansion of the early childhood population to be served under the act.

Second is the amendment requiring that States develop policies and procedures that will insure that school children with disabilities receive services from professionals who meet the same high standards as professionals who serve adults and children in other public and private agencies.

PREPARED STATEMENT

Finally, Mr. Chairman, we are aware of the pressures on Congress to reduce the Federal budget deficit and deal with the Federal debt problem. These are problems that we all face as a nation and its people; but we must remember that, in the words of John F. Kennedy, the power of the budget is the power to choose. We must also remember that these budget choices are not the mere juggling of revenues and expenditures. They reflect the goals, the values, the hopes of society. Certainly appropriate education and quality health care for children must remain among our highest priorities. For children that happen to have disabilities, these are goals that must not be postponed for any reason.

Senator CHILES. Thank you very much. We appreciate your testimony.

[The statement follows:]

STATEMENT OF ROGER P. KINGSLEY

The American Speech-Language-Hearing Association (ASHA) is pleased to have the opportunity to present its views and recommendations regarding Fiscal Year 1988 appropriations for several programs authorized by the Education of the Handicapped Act. We have already joined with other professional associations and disability organizations that make up the Consortium for Citizens with Developmental Disabilities (CCDD) in making recommendations for numerous education, rehabilitation and health programs under the jurisdiction of this Subcommittee. Therefore, this statement will focus on just two areas -- (1) the new and expanded early childhood programs; and (2) special education personnel development.

Persons with physical and mental disabilities comprise a substantial portion of the nation's population -- over 36 million people. Among the most prevalent handicapping conditions are speech, language, and hearing impairments. According to U.S. Census data for 1980, there were approximately 2.6 million people with speech and language impairments and over 18 million people with hearing impairments.[1] Because the ability to communicate effectively is so fundamental to other life activities -- learning, interpersonal relationships, vocational pursuits -- any loss or limitation of this ability can be detrimental to an individual's development and performance and to his or her overall quality of life.

As the professional and scientific association representing over 52,000 speech-language pathologists and audiologists nationwide, ASHA is very concerned about adequate support of service, training, and research programs for persons with physical and mental disabilities who have primary or secondary communication disorders. Because the programs addressed here are demonstrably cost effective, adequate funding is essential in terms of national economic as well as individual human considerations.

Education of the Handicapped Early Intervention and Preschool Grant Programs

Years of research and experience demonstrating the efficacy of providing early intervention services to infants and preschool-age children with handicaps, resulted in the enactment of the Handicapped Infants and Toddlers Program and a new Preschool Grant Program as part of the Education of the Handicapped Act Amendments of 1986 (P.L. 99-457).

In submitting the Administration's FY 1988 Budget, Secretary of Education William Bennett stated that a "high priority in our budget is programs for the handicapped."[2] Despite this rhetoric, the Administration's actual proposal would reduce total spending for Education of the Handicapped Act programs by $253.7 million from the current level of $1,741.9 million. Particularly disturbing is the request of zero funding for the new early intervention program, Part H of the Act. This request is puzzling in light of a statement made by an official of the Department of Education on P.L. 99-457: "I am pleased to inform you that the President signed S. 2294 on October 8, 1986...Providing services to these children before they reach school age can result in greater educational achievement and can reduce their dependence on others as they grow older. These children are especially deserving of our assistance so that they may reach their fullest potential."[3]

The Part B Preschool Grant Program replaces the Preschool Incentive Grant Program and is intended to assist the states in ensuring that all children with disabilities ages 3 to 5, inclusive, receive special education and related services by the 1990-91 school year. Enactment of this program represents the latest important step in the long evolution of federal support toward achieving full educational opportunities and services for preschool age children with disabilities. The Administration, in its budget request, rejects the need to provide additional federal support for preschool services and proposes to slash funding from $180 million to $85 million for the program.

During the 1984-85 school year, 75 percent or 260,000 children with disabilities ages 3-5 were being served by the states. The vast majority of these children (70.5 %) had a primary handicap of speech or language impairment.[4] This does not include the large number of children with other primary handicaps (e.g., mental retardation, cerebral palsy, learning disability, hearing impairment) who have concomitant speech or language disorders. Because services to children with disabilities below the age of three have been available in some states and in some programs but not others, few data exist on the overall prevalence of children served and unserved in this age group. We do know, however, that there is a substantial need for services to children ages birth through five who have communication disorders.

A 1985 ASHA survey found that children ages 0-5, inclusive, comprised 26.8 percent of the caseloads of speech-language pathologists.[5]

Based on the documented need for services to young children with disabilities and on the congressional commitment of increased support for programs serving this population, ASHA makes these recommendations for FY 1988 funding: For the Preschool Grant Program, $216 million, which represents the amount needed to keep pace with the movement toward full preschool services, as determined by Congress under the design of P.L. 99-457.[6] For the Infants and Toddlers Program, $75 million, which is the full authorized amount.

Special Education Personnel Development

One of the most important discretionary programs in the Education of the Handicapped Act is the Special Education Personnel Development program (Part D). Without properly trained, accessible, and sufficient personnel, it is difficult to envision the successful implementation of the primary goal of P.L. 94-142 -- attainment of a free and appropriate public education for all handicapped children. Yet, the Administration's budget request would cut personnel preparation funding by $17.7 million, or 26%, relative to the current level. Once again, the rationale for these cuts is that "data available do not support the need for the increases in funding Congress has provided for the program."[7] This contradicts the findings of personnel shortages as reported in the Department's annual report on the implementation of the Education of the Handicapped Act.[8]

We believe that the need for increased federal support for Special Education Personnel Development is greater than ever as a result of two changes made by P.L. 99-457. The first relates to the expansion of services to children in the birth through five age range and the need to train additional personnel to serve this population. The second relates to the new "qualified personnel" provision under which states must ensure that personnel providing special education and related services meet state licensure or professional certification standards.

The Department of Education reports that the number of special education teachers has risen annually since the implementation of P.L. 94-142 began in 1976. However, the Department also found that 17,103 additional special education teachers were needed and that serious shortages exist in several areas including multihandicapped, hard-of-hearing and deaf.[9] The personnel problem is actually more serious than these figures indicate because they do not take into account the number of special education personnel who are unqualified or underqualified to serve children with particular kinds of disabilities.

The authors of a major study of special education personnel stated that

> "When supplies of any resource are plentiful, the tendency is to sort and select the superior; when supplies are scant, one settles for less. In special education, the most widespread solution to problems of personnel shortages and recruitment problems is the issuance of certificates to persons who do not demonstrate the preparation, experience, qualifications, and other criteria ordinarily used for certification...[10]

The study also reported that "Undersupplies of personnel in speech/language/communication...present themselves as serious national needs."[11]

The problem of unqualified personnel was an issue brought to the attention of and recognized by Congress during last year's reauthorization of the Education of the Handicapped Act. The final report (House Report No. 99-860) accompanying the legislation stated:

> The Committee is concerned about the increasing number of personnel providing special education and related services who do not meet the highest State standards established for employment in a specific profession or discipline. For example, many teachers providing special education have been issued temporary teaching certificates and do not meet the full certification standards related to the area in which they provide instruction. The Committee intends that the States will take steps to ensure that all special education teachers are fully qualified and certified for the area in which they are providing instruction.
>
> The Committee also is concerned that some States have established education and training requirements for individuals providing services that do not apply to all members of that profession employed by State and local educational agencies. For example, 19 States currently require a speech-language pathologist to have a master's degree to legally provide services to handicapped infants and youth in a non-public agency. However, in these same States, the State educational agency allows individuals with less than a master's degree to provide services to handicapped infants, children and youth in the schools. The Committee hopes that States will take steps to ensure that professionals providing special education and related services meet appropriate professional requirements to practice a specific profession or discipline.[12]

As a result, P.L. 99-457 amends the state grant programs (Parts B and H) to require that state plans include steps that will be taken to ensure that personnel meet the highest standard for qualification to practice in a particular professional discipline.

The problem of inadequately trained personnel is most serious in the field of speech-language pathology. Although the master's degree has been the professionally accepted standard for twenty years, there are still 23 states (and the District of Columbia) in which education certification standards allow an individual with a bachelor's degree to provide services to children with communication disorders (three more states have decided to raise their standards to the master's degree level between now and 1990). Ironically, 19 of these states have licensure laws requiring that speech-language pathologists providing services in public health agencies, non-public agencies, and in private practice, must have a master's degree. Hence, in these states there is a clear double standard: a high quality standard for adults and children with communication disorders who are diagnosed and treated outside of the school system; and a lesser quality standard for children receiving services in the schools.

Now that Congress has mandated that states develop plans to ensure the use of qualified personnel, we suggest that funding be targeted at states in which current standards need to be modified and where additional resources can be used to build an adequate workforce. Specifically, we recommend that the Secretary of Education make grants through a special competition to institutions of higher education and other appropriate non-profit agencies to conduct projects to prepare or retrain speech-language pathologists and audiologists to work in states with documented shortages of qualified professionals to serve individuals with communication disorders.

We also recommend that the full authorized amount, $74.5 million, for Special Education Personnel Development be appropriated for FY 1988. This level of funding will enhance the training of qualified personnel, parents, and other special education and related services professionals who serve children under the broadened scope of the Act.

ASHA is pleased to have had the opportunity to present its views on these special education programs. We look forward to working with members and staff of the Subcommittee as it considers FY 1988 funding allocations for the important human services programs under its jurisdiction.

Notes

1. U.S. Bureau of the Census, 1982a Preliminary Estimates of the Population of the United States.
2. William J. Bennett, Secretary of Education, Statement on the Fiscal Year 1988 Budget (January 5, 1987).

3. Frances M. Norris, Assistant Secretary for Legislation, Department of Education, letter (October 16, 1986).

4. U.S. Department of Education, Office of Special Education Programs, Eighth Annual Report to Congress on the Implementation of the Education of the Handicapped Act (1986), p. 9.

5. American Speech-Language-Hearing Association, Omnibus survey (1986).

6. U.S. House of Representatives, Report No. 99-860, Education of the Handicapped Act Amendments of 1986 (September 22, 1986), pp. 18-19.

7. Department of Education, The Fiscal Year 1988 Budget, p. 22.

8. U.S. Dept. of Ed. Eighth Annual Report, pp. 69-72.

9. U.S. Dept. of Ed. Eighth Annual Report, p. 68.

10. Smith-Davis, J., Burke, P., Noel, M., Institute for the Study of Exceptional Children and Youth, Personnel to Educate the Handicapped in America: Supply and Demand From a Programmatic Viewpoint (1984), pp. 229-30.

11. Smith-Davis et al., p. 52.

12. House Report 99-860, p.38.

Senator CHILES. Now we will hear from Senator Larry Hill. Is Senator Hill here?

Representative Arthur Tufts.

STATEMENT OF ARTHUR TUFTS, STATE REPRESENTATIVE, NEW HAMPSHIRE, ON BEHALF OF THE NATIONAL RECREATION AND PARK ASSOCIATION

Mr. TUFTS. Mr. Chairman.

Senator CHILES. How do you do, Representative Tufts. We are delighted to have you with us.

Mr. TUFTS. I am Arthur Tufts, nurseryman, State representative in the New Hampshire general court, chairman of the House Education Committee, former president of the Senate.

I am speaking on behalf of the National Recreation and Park Association [NRPA] and its National Therapeutic Recreation Society branch. NRPA is a national nonprofit organization engaged in a wide range of research, education, policy and program initiatives involving parks and recreation. The association has a membership of over 19,000 individuals, organizations and agencies performing an array of civic, professional and technical functions to meet diverse recreational needs.

The National Therapeutic Recreation Society includes those who have a particular interest and expertise in the provision of recreation for special populations and who use recreation as an essential part of the rehabilitation process. The association appreciates this opportunity to express its views on appropriations for the special recreation programs authorized under section 316 of the Rehabilitation Act of 1973.

We urge you to support the continuation of funds for projects which initiate recreation services for persons with disabilities. We recommend a fiscal year 1988 appropriation of $2.4 million for special recreation programs for persons with disabilities. This request reflects an emphasis on enhanced community integration, an expanded scope of service delivery, and a new grant length of 3 years.

This recommendation is endorsed by the Consortium of Citizens with Developmental Disabilities, a coalition of over 60 national consumer, professional and provider organizations concerned with those in society most in need of our support.

In fiscal year 1987, program priority has been given to supporting services in the least restrictive environment that enable increased independence and integration in with the community. Recent research on the efficiency of special recreation projects has shown that Federal grant support can and does improve the rehabilitation and independence of persons with disability.

In addition, special recreation program funding has increased cooperative efforts among therapeutic recreation specialists in clinical and community settings.

Despite evidence of progress, the need for recreation programs as a key part of the community integration and dependence of persons with disability continue to exist. While the special recreation programs have proven very effective, the administration proposes no funding for fiscal year 1988. This appropriation request comes at a time when the program reaches 17,000 individuals yearly and is growing in popularity among recreation providers.

Now structured in 3-year lengths, program grants hold new promise to increase the effectiveness of recreation projects as information is gathered on the characteristics of the most successful.

In 1979 the New Hampshire general court passed legislation establishing a position of therapeutic recreation specialist. The position was funded and filled and has provided activities and resources which aid in promoting worthy use of leisure time, pursuit of happiness and fullness of life to individuals, groups, municipalities, and other political subdivisions of the State of New Hampshire and to nongovernmental organizations and agencies.

Other States have benefited from section 316 funds, including three separate programs in Florida, Connecticut, and Minnesota. We believe that continued assistance for special recreation programs authorized by section 316 is critical if more people with disabilities are to enter the mainstream of society.

PREPARED STATEMENT

Recreation aids the social, emotional, and physical well-being of all people. For persons with disabilities, it is critical for their becoming a functioning, integral part of society. I thank you very much.

Senator CHILES. Thank you very much for your testimony. We are delighted to have you here today.

[The statement follows:]

STATEMENT OF ARTHUR TUFTS

Mr. Chairman and members of the Subcommittee, I am Arthur Tufts, State Representative from New Hampshire and speaking on behalf of the National Recreation and Park Association and its National Therapeutic Recreation Society branch.

NRPA is a national non-profit organization engaged in a wide range of research, education, policy and program initiatives involving parks and recreation. The Association has a membership of over 19,000 individuals, organizations an agencies performing an array of civic, professional and technical functions to meet diverse recreation needs. The National Therapeutic Recreation Society includes those who have a particular interest and expertise in the provision of recreation for special populations, and who use recreation as an essential part of the rehabilitation process.

The Association appreciates this opportunity to express its views on appropriations for Special Recreation Programs authorized under Section 316 of the Rehabilitation Act of 1973, as amended. We urge you to support the continuation of funds for projects which initiate recreation services for persons with disabilities.

We recommend a fiscal 1988 appropriation of $2.4 million for Special Recreation Programs for persons with disabilities. This request reflects an emphasis on enhanced community integration, an expanded scope of service delivery and a new grant length of three years. This recommendation is endorsed by the Consortium for Citizens with Developmental Disabilities, a coalition of over 60 national consumer, professional and provider organizations concerned with those in society most in need of our support.

In FY 1987, program priority has been given to supporting services in the least restrictive environment that enable increased independence and integration in the community. Recent research on the efficacy of special recreation projects has shown that federal grant support can and does improve the rehabilitation and independence of persons with disablilities. In addition, Special Recreation Programs funding has increased cooperative efforts among therapeutic recreation specialists in clinical and community settings, thereby assisting persons with disabilities in transitional adjustments to work and community living. Projects provide a broad range of activities and related experience including sports, music, dance, arts and crafts, camping and scouting, as well as leisure education and resource development.

Despite evidence of progress, the need for recreational programs as a key part of community integration and independence of persons with disabilities continues to exist. A nationwide survey of 1,000 persons with disabilities by Louis Harris and Associates revealed that these individuals typically socialize less with friends and family and are less involved in community activities.

Continued need is also evident in the more than 200 proposals that are submitted to the Rehabilitation Services Administration each year to fund special recreation projects. Only about 30 proposals can ultimately be funded. The 150 projects that have been funded since 1980 have resulted in an expansion of recreational opportunities directly impacting over 100,000 persons with disabilities.

While the Special Recreation Programs has proven very effective, the Administration proposes no funding for fiscal 1988. This appropriation request comes at a time when the program reaches 17,000 individuals yearly and is growing in popularity among recreation providers. Applications for grants have risen seven percent from last year, to 240. RSA also reports that it has received the greatest level of interest yet shown about the program during this year's application period.

Now structured in three-year lengths, program grants hold new promise to increse the effectiveness of recreation projects as information is gathered on the characteristics of the most successful. Unfortunately, programs enrolled in three-year grants are in jeopardy of ending prematurely if acceptable appropriations levels are not maintained. More limited appropriations for Special Recreation Programs would also reduce or eliminate potential new projects and negatively impact on the number of persons served.

We believe that continued assistance for Special Recreation Programs authorized by Section 316 is critical if more people with disablilities are to enter the mainstream of society. Recreation aids the social, emotional, and physical well-being of all people. For persons with disabilities, it is critical for their becoming a functioning, integral part of society.

Senator CHILES. Now we will hear from Mr. Karl Funke, president of the Council on Energy Resource Tribes.

[No response.]

STATEMENT OF DANIEL RUTHERFORD, ILLINOIS COLLABORATION ON YOUTH

Senator CHILES. All right, we will hear from Dan Rutherford, Illinois Collaboration on Youth.

Mr. RUTHERFORD. Mr. Chairman and members of the committee, my name is Daniel Rutherford, and I am here representing the Illinois Collaboration on Youth. I would like to speak to you today on behalf of young people. I am 21 years old. I have a job, and I am living in the Independent Living Program that is operated by Aunt Martha's Youth Service Center. This shelter is one of many programs that Aunt Martha operates in Chicago's southern suburbs.

I am moving forward in my life. I plan soon to be living independently in my own apartment. My future did not always look so bright. I was born in Rockford, IL, and I lived with my parents until I was 18. At the age of 18, I enlisted in the U.S. Navy. At 19 I was inducted but I had my problems in the Navy.

I was discharged after 7 months because of learning disabilities. At age 20 I found myself discharged and no place to go. The Navy had given me money, so I bought a car to use it only to look for jobs; but since I had nowhere to live, I lived in my car for about 4 months. In the meantime, I was trying to help myself. So I called my cousin up to say give me a job at Wisconsin. When I got there, he did not hire me, so I turned myself around back to Chicago.

Everything just went downhill from there. I started drinking and using illegal drugs. When I reached the bottom I got in trouble for drunk driving, and I lost my car. When I lost my car, I lost my home.

After that, I was running out of choices. I lived in a church in Oak Lawn, IL, for about 1 week. Toward the end of the week, I went to the township to apply for general assistance funds. The township suggested that I call the Southwest YMCA. I called, and a worker came and got me. She took me to the Aunt Martha's Shelter in Harvey, IL, and I have been there ever since. That was last August.

Life since has not been easy, but the direction has been positive. Through Aunt Martha's I got help with my drinking and drug problem. I have been drugfree for the last 4 months. I also went through Aunt Martha's Youth Employment and began working part time in January, and I found a full time 2 months ago. I work in the catering department of Chicago Board of Option Exchange as a runner making deliveries. It is a good place to work, and it is a great beginning for me.

I am looking for an apartment now and will soon be living on my own, working on my own and taking care of all my needs, just like millions of young adults do today. Nine months ago this simple life seemed out of reach for me.

My life is on track now, and I am growing stronger all the time. I am strong enough to help myself, and I believe I am strong enough to begin to help other young people who through lack of available services and luck may not receive the second chance that Aunt Martha's has given me.

I understand that on April 9 the Senate passed legislation which provide aid to the homeless. On behalf of the Illinois Collaboration on Youth and all young people in need, I urge your support for full funding for this program as you move toward completing your work on this important legislation.

Thank you.

PREPARED STATEMENT

Senator CHILES. Dan, we thank you very much here. Your testimony is very eloquent. I know that it is kind of tough for you to come up here, but I want you to know you are a good advocate. You speak more than a lot of people could, and I am delighted to see what you are doing with your life now. It sounds like you are getting hold of it and really turning it around. I congratulate you, and it is nice that you are now wanting to help some other people. Thank you very much for coming here today.

[The statement follows:]

STATEMENT OF DANIEL RUTHERFORD

My name is Dan Rutherford, and I am here representing the Illinois Collaboration on Youth (ICOY), a membership association comprised of approximately one hundred community based youth service agencies throughout the State of Illinois.

I would like to speak with you today on behalf of young people who are in need of the kind of services provided by ICOY member agencies. I especially would like to talk with you about young people like myself, who are in desperate need of services, and unlike myself, may not have been fortunate enough to have these services available in their communities.

Today, I am 21 years old, I have a job, and I am living in the Transition to Independence Project that is operated by Aunt Martha's Youth Service Center. This shelter is one of many programs that Aunt Martha's operates in Chicago's southern suburbs. I am moving forward with my life, and I plan to soon be living independently in my own apartment, with the continued support and friendship of the staff from Aunt Martha's. But I didn't always feel my future looked so bright.

I was born in Rockford, Illinois, and lived with my family in many different places around the country until I was about 18 years old. I have a family, but for me, let's say that my family couldn't meet my needs growing up, and I couldn't meet the expectations they had for me. When I was 18, I enlisted in the Navy, and was inducted when I was 19. But I had my problems making it in the Navy, and I was discharged after 7 months because I had a learning disability. Because of my learning disability, I just couldn't make the grade on the tests I needed to pass.

So, at age 20, I found myself discharged from the Navy, with nowhere to go. I could have lived with my family, and I tried it for about a week, but I think all of us knew that it just wouldn't work out. The Navy had given me a little money when I got discharged, so I bought a car. I thought a car would be an important thing to have, because I wanted to find a job. I thought I would need a car to look for a job, and to use to get to and from work. Because I didn't have any place else to go, I lived out of my car for about four months. I didn't plan for things to work out that way, but it just sort of happened.

In the meantime, I tried to use the resources I knew of to help myself. I have a cousin who runs a bakery in Wisconsin, and he said he'd give me a job. I went up there to work, but when I got there, he wouldn't hire me. I turned around and came back to Chicago, but things just went from bad to worse. I didn't have control of my life, and I lost control of myself. I was drinking and using drugs, and my life was on a down-hill slide. I reached the bottom when I got in trouble for drunk driving, and I lost my car. When I lost my car, I also lost my home.

After that, I was running out of choices. I lived in a church in Oak Lawn, Illinois for about a week (that was as long as they'd let me stay). Toward the end of that week, I went to the township to apply for General Assistance funds. That turned into the beginning of new hope for me. Because I was under 21, the township suggested that I call the Southwest YMCA, to see what programs they might have for me. I called, and a worker from Southwest Y came and got me. She took me to Aunt Martha's shelter in Harvey, and I've been there ever since.

That was last August. Life since then hasn't been easy, but the direction has all been positive. Through Aunt Martha's, I got help with my drinking and drug problem. I have completed the program, and I have been drug-free for the last four months. I also went through Aunt Martha's youth employment program. I began working part-time in January, and I found a full-time job two months ago. I work in the catering department of the Chicago Board of Options Exchange, as a runner making deliveries. It's a good place to work, and a great beginning for me. I am looking for an apartment now, and soon I will be living on my own, working on my own, and taking care of all my needs, just like millions of young adults all over the country. But nine short months ago, this simple life seemed a dream as out of reach for me as the thought that I might some day be testifying before the United States Senate!

My life is on track now, and I am growing stronger all the time. I am strong enough to help myself, and I believe that I am strong enough to begin to help other young people who, through lack of available services and luck, may not receive the second chance at life that my experience at Aunt Martha's has given me.

I understand that on April 9, the Senate passed HR588. This legislation, which provides aid to the homeless, will be presented for your consideration for funding at a level of 42[illegible] million dollars. On behalf of the Illinois Collaboration on Youth, and all young people in need, I urge your support of full funding for this initiative as you move toward completing your work on this important legislation.

STATEMENT OF ELOUISE ELLIS, CHAIRPERSON, DISTRICT OF COLUMBIA STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS

Senator CHILES. Now, I would like to hear from Elouise Ellis, American Association of Retired Persons.

Elouise, I will be right back.

[Pause.]

Thank you. Go ahead.

Ms. ELLIS. Good morning, Chairman Chiles. On behalf of the more than 25 million working and retired members of the American Association of Retired Persons [AARP], thank you for this opportunity to testify concerning fiscal year 1988 funding for programs under this subcommittee's jurisdiction. My name is Elouise Ellis, chair of the D.C. State Legislative Committee.

The association recommends that funding for Older Americans Act programs be continued at no less than fiscal year 1987 levels. Today, older persons are able to live independently in their own homes because of title III supportive services. In addition, the title III meals program provides needed nutrition as well as opportunities for socialization.

Title IV research and demonstrations have also yielded impressive results despite a modest investment. Some of the most innovative and effective programs in the field of aging have evolved from Older Americans Act demonstrations, including the nutrition program for the elderly, foster grandparents and others.

AARP further recommends title V of Older Americans Act, the Senior Community Service Employment Program, be funded at $336 million during fiscal year 1988. This reflects the $10 million increase containing in the House supplemental appropriations bill for fiscal year 1987. Title V can be an effective means for low income older Americans to help themselves while helping others in their communities.

AARP also recommends expansion of funding for education assistance programs. AARP is pleased that the 1987 higher education amendments greatly expanded financial aid opportunities for part-time students, often older, nontraditional students.

AARP urges this subcommittee to maintain appropriations for the Supplemental Education/Opportunity Grant Program for institutions, the College Work Study Program, and the National Direct Student Loan Program.

In addition, the association urges this committee to appropriate sufficient funds to raise the maximum Pell grant benefit to $2,500 as authorized.

AARP supports funding of the Low Income Home Energy Assistance Program at the fiscal year 1987 level of $2.1 billion. This is the optimized level of spending for fiscal year 1988 and restores funds that were cut last year based on conditions that no longer pertain. Energy assistance is extremely important to older Americans who are especially vulnerable to heat stroke and hypothermia. Older consumers spend a higher percentage of their income on home energy than younger people, and those with low incomes must also spend disproportionately.

Thirty-nine percent of LIHEAP households contain at least one elderly person. Even so, fewer than one-third of eligible households participated in LIHEAP due to chronically inadequate funding.

The association supports funding for the social services block grant at no less than $2.8 billion. This figure reflects a $1 million increase over current funding as assumed in the fiscal year 1988 budget resolution reported by the House Budget Committee. Social services block grant provides critically important services that help low-income older Americans and others to maintain their independence and avoid inappropriate institutionalization.

Finally, the association recommends that the community service block grants be continued at $368 million during fiscal year 1988 and further recommends adequate funding for administrative cost reimbursement to Medicare carriers and intermediaries.

PREPARED STATEMENT

In conclusion, Mr. Chairman, AARP appreciates the subcommittee's careful consideration of these recommendations and stands ready to work closely with members and staff as you proceed toward markup of the bill for fiscal year 1988.

Senator CHILES. Thank you very much. We are delighted to have you.

[The statement follows:]

STATEMENT OF ELOUISE ELLIS

On behalf of the more than 25 million working and retired members of the American Association of Retired Persons thank you for this opportunity to testify concerning FY 1988 funding for programs under this Subcommittee's jurisdiction. My name is Elouise Ellis, volunteer and Chair of the District of Columbia State Legislative Committee.

A. Older Americans Act/Administration on Aging

The Association recommends that funding for Older Americans Act programs should be continued at no less than fiscal year 1987 levels. This would effectively fund Older Americans Act programs under the direction of the Administration on Aging at $724.7 million: the Federal Council on the Aging, $200,000; supportive services and senior centers, $270 million; congregate meals, $348 million; home-delivered meals, $74 million; research, training, and demonstration projects, $25 million, and grants to Indian tribes, $7.5 million.

Today, many aged persons are able to live independently in their own homes because of Title III supportive services. In addition, the congregate meals program provides needed nutrition as well as opportunities for socialization. For those older persons unable to visit a meal site, the home-delivered meals program enables such individuals to live independently in their homes, rather than be placed in a nursing home at a much higher public cost.

Title IV training, research and demonstrations have also yielded impressive results, despite a modest investment. Some of the most innovative and effective programs in the field of aging have evolved from Older Americans Act demonstrations, including the nutrition program for the elderly, Foster Grandparents, the Retired Senior Volunteer Program, educational television activities, legal services, and improved services to minority older persons. Career preparation training, also supported by Title IV, has produced a cadre of qualified professionals in the field of aging.

B. Senior Community Service Employment Program

AARP recommends that Title V of the Older Americans Act should be funded at $336 million during FY 1988. This reflects the $10 million increase contained in this Subcommittee's Supplemental Appropriations bill for FY 1987. This inceased funding would boost the number of Title V positions by about 1,960, from 63,780 under the existing appropriation to 65,740.

The importance of incorporating this increase cannot be underrated: the poverty rate rose for persons 55 years of age or older in 1985, the latest year that census information is available. However, poverty declined for persons under 55 years of age from 1984 to 1985. Title V can be an effective means for low-income older Americans to help themselves while helping others in their communities at the same time.

C. Education Programs

Last year Congress enacted legislation -- the 1987 Higher Education Amendments -- which greatly expanded financial aid opportunities for part-time students, often older, non-traditional students.

AARP further urges this Subcommittee to maintain appropriations for the Supplemental Educational/Opportunity Grant program for institutions, the College Work Study program, and the National Direct Student Loan program.

In addition, the Association urges this Subcommittee to appropriate sufficient funds to raise the maximum Pell Grant benefit to $2,500, as authorized.

D. Low Income Home Energy Assistance Program (LIHEAP)

AARP supports funding of the Low Income Home Energy Assistance Program at the FY 1987 level of $2.1 billion. This is the authorized level of spending for FY 1988, and restores funds that were cut last year on the basis of declining energy prices and the availability of oil overcharge funds to the states. These conditions no longer pertain and it is essential that full funding for low income energy assistance be restored.

LIHEAP is extremely important to older Americans, who are especially vulnerable to heat stroke and hypothermia. Older consumers spend a higher percentage of their income on home energy than younger people, and those with low incomes must also spend disproportionately.

Although LIHEAP paid a portion of the heating bills for some 6.8 million households in FY 1985, less than a third of all households who are eligible to participate in LIHEAP actually receive benefits, primarily due to chronically inadequate funding.

E. Social Services Block Grant (SSBG)

The Association supports funding of the Social Services Block Grant at no less than $2.8 billion. This figure reflects a $100 million increase over current funding as assumed in the FY 1988 budget resolution reported by the House Budget Committee. SSBG provides critically important services that help low income older Americans that helps them to maintain their independence through coordination with other federal, state, local and private programs and initiatives.

F. Community Services Block Grant (CSBG)

The Association recommends that the Community Servcies Block Grant be continued at $368 million during FY 1988. A GAO study recently found that CSBG funds are used for services and frequently funds administration of other federal programs that otherwise could not fulfill their missions.

Services funded by CSBG likewise tend to support other services and often make access to them possible. Without information, referral and outreach--which represent the most common CSBG-funded activities--many homebound or islolated older persons would be unaware that emergency food or energy assistance is available to them.

G. Medicare Contractor Funding

AARP urges this Subcommittee to appropriate adequate funds for administrative expense reimbursement to Medicare carriers and intermediaries. Adequate funding is necessary in order to assure expedient and efficient service in the administration of the Medicare program.

Medicare intermediaries and carriers are being placed in a "Catch-22" situation. While funds have been reduced due to Gramm-Rudman budget cuts, the volume of claims and the number of administrative changes in the Medicare program continue to grow.

A continuation of inadequate administrative reimbursements to intermediaries and carriers will produce several negative results: (1) further delays in processing payments for physicians, suppliers, and beneficiaries; (2) reduce carriers' ability to perform quality utilization reviews, which could result in more payment errors and higher costs; and (3) curtailment or elimination of services to beneficiaries.

CONCLUSION

AARP appreciates the Subcommittee's careful consideration of these recommendations and stands ready to work closely with Members and staff as you proceed toward markup of a bill for FY 1988.

STATEMENT OF RICHARD MAPP, VICE PRESIDENT, THE NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

Senator CHILES. Now, we will hear from Richard Mapp from the National Caucus and Center on Black Aged, Inc.

Mr. MAPP. Chairman Chiles, my name is Richard Mapp, vice president of the National Caucus and Center on Black Aged [NCBA]. Our president, Mr. Samuel Simmons, was called earlier this week to attend initial closing ceremonies for our sponsored 202 housing project down in Mississippi, so he cannot be here today. On his behalf, however, NCBA welcomes the opportunity to present testimony on the fiscal year 1988 Labor-HHS, Education appropriation bill.

As the only national organization focusing exclusively on the needs of aged blacks, NCBA will direct its testimony to certain appropriations issues. With your permission, Mr. Chairman, we wish to submit our prepared statement for the record and highlight just some major points.

Senator CHILES. It will be included.

Mr. MAPP. Thank you.

First, NCBA supports the Roybal-Biaggi amendment to provide a $10 million funding increase for the Title V Senior Community Service Employment Program in the Fiscal Year 1987 Supplemental Appropriations Act. This measure will provide an additional 1,957 positions with title V and raise the total from 63,784 to 65,741. We urge your subcommittee to work for the Senate's enactment of this House amendment.

Second, we also urge the subcommittee to appropriate at least $236 million for title V of fiscal year 1988. If sufficient flexibility exists, we recommend that the subcommittee provide a funding increase. The Senior Community Service Employment Program, as valuable and as important as it is, still reaches only about 1 percent of all potentially eligible low income seniors.

NCBA's experience demonstrates that there are numerous aged blacks and other low income older Americans who are ready, willing and able to work if given the chance. Many of these individuals quite frankly may not now be good candidates for employment in the private sector because of their limited education, their long-term detachment from the work force or their obsolete work skills.

The net impact is that this program has taken some of the most economically deprived older Americans in our society and has provided them with a new lease on life. NCBA urges, therefore, that the Senior Community Service Employment Program should be funded at $336 million for fiscal year 1987 and at least at that level for fiscal year 1988.

NCBA further urges the subcommittee to reject the proposed generic appropriation for the Older Americans Act and nearly all other programs under the jurisdiction of the Office of Human Development Services, including Head Start, Child Abuse, Child Welfare, Runaway Youth, Developmental Disabilities and Native Americans. NCBA is concerned that these may pave the way for block granting the Older Americans Act.

Moreover, this proposal would make it much more difficult to assign accountability for Older Americans Act functions. As a practical matter, the Older Americans Act would lose much of its identity and visibility. NCBA believes that the Older Americans Act should be made a separate categorical program.

Before discussing our funding recommendations for AOA activities, we wish to commend this subcommittee for rejecting the proposed shifting of $12.5 million of fiscal year 1987 funds from title V to other OHDS activities, $11.1 million for foster care and $1.4 million for salaries and expenses. This measure would have seriously undermined title IV, which already suffered sharp funding reductions during the early 1980's.

NCBA supports a solid title IV program as a necessary component to complement title III supportive and nutrition services.

Finally, Mr. Chairman, we call upon the subcommittee to include report language to promote career preparation training for minorities especially at historically black colleges and universities. This is essential to emphasize that career level education for minority group individuals is a high priority goal. It is also crucial to attract more minorities into the field of aging.

PREPARED STATEMENT

We wish to thank you for the opportunity to testify today.

Senator CHILES. Thank you, sir. We appreciate your testimony.

[The statement follows:]

STATEMENT OF RICHARD MAPP

Mr. Chairman and Members of the Subcommittee, the National Caucus and Center on Black Aged welcomes the opportunity to present testimony today on the fiscal year 1988 Labor-HHS-Education Appropriations bill. As the only national organization focusing exclusively on the needs of aged Blacks, NCBA will direct its testimony to appropriations issues affecting elderly Blacks.

NCBA's testimony will concentrate primarily on two key areas: (1) the Title V Senior Community Service Employment Program, which is under the direction of the Department of Labor, and (2) the remaining Older Americans Act programs which are administered by the Administration on Aging.

Senior Community Service Employment Program

First, NCBA supports the Roybal-Biaggi amendment to provide a $10-million funding increase for the Title V Senior Community Service Employment Program (SCSEP) in the Fiscal Year 1987 Supplemental Appropriations Act. This measure would provide an additional 1,957 positions for Title V, raising the total from 63,784 to 65,741.

We urge the Subcomittee to work for enactment of this amendment. Title V is one of the most effective programs ever developed for aged Blacks and other elderly persons. It is an enormously popular program which could easily be funded substantially above the current amount.

NCBA's Senior Employment Program (SEP), for example, typically has several applicants for each available position. This situation is also true for other SCSEP sponsors. Consequently, our advertising is limited because NCBA does not want to create false hopes for low-income senior citizens who want or need to work.

We also urge the Subcommittee to appropriate at least $336 million for Title V for fiscal year 1988. If sufficient flexibility exists, we recomend that the Subcommittee provide a funding increase. The Senior Community Service Employment Program--as valuable and as important as it is--still reaches only about 1 percent of all potentially eligible low-income seniors.

NCBA's experience demonstrates that there are numerous aged Blacks and other low-income older Americans who are ready, willing and able to work, if given the chance. Many of these individuals quite frankly may not now be good candidates for employment in the private sector because of their limited education, their long-term detachment from the work force, or their obsolete work skills.

Title V, however, provides hope and opportunity for these disadvantaged older workers. It provides them with on-the-job experience and training to move into gainful employment. In short, the Senior Community Service Employment Program provides a helping hand, not a handout.

Over the years, Title V has consistently received strong bipartisan support from the Congress because it has been an extraordinarily successful program. The Senior Community Service Employment Program has enabled low-inome older Americans to improve their economic well-being while providing much-needed and beneficial services in their communities. The program has not been marred by rampant fraud or abuse. Its administrative costs are low. Title V has been effective in moving older Americans into private sector employment. The net impact is that the SCSEP has taken some of the most economically deprived older Americans in our society, and has provided them with a new lease on life.

Title V is a "win-win" situation for all concerned. For these reasons, NCBA reaffirms that the Senior Community Service Employment Program should be funded at $336 million for fiscal year 1987 and at least at that level for fiscal year 1988.

Older Americans Act/Administration on Aging

NCBA further urges the Subcommittee to reject the proposed generic appropriation for the Older Americans Act and nearly all other programs under the jurisdiction of the Office of Human Development Services (OHDS), including Head Start, Child Abuse, Child Welfare, Runaway Youth, Developmental Disabilities, and Native Americans.

NCBA is concerned that this may pave the way for block granting the Older Americans Act. Moreover, this proposal would make it much more difficult to assign accountability for Older Americans Act functions. As a practical matter, the Older Americans Act would lose much of its identity and visibility.

NCBA believes that the Older Americans Act should remain a separate categorical program. Congress decided upon this course of action when it enacted the Older Americans Act more than two decades ago. During its existence, the Older Americans Act has functioned well as a categorical program. We see no reason to change this overall approach. It has basically worked well, and should be continued.

Before discussing our funding recommendations for Administration on Aging activities, we wish to commend this Subcommittee for rejecting the proposed shifting of $12.5 million of fiscal year 1987 funds from Title IV Research, Training, and Demonstrations to other OHDS activities--$11.1 million for Foster Care and $1.4 million for salaries and expenses. This measure would have seriously undermined Title IV, which already suffered sharp funding reductions during the early 1980's. NCBA supports a solid Title IV program as a necessary component to complement Title III Supportive and Nutrition Services.

NCBA recommends that Older Americans Act activities under the direction of the Administration on Aging should be maintained at least at the fiscal year 1987 levels. Overall, this amounts to $724.7 million. If sufficient flexibility exists, NCBA proposes that funding increases be enacted.

We also call upon the Subcommittee to include report language to promote increased services for aged minorities under the Title III Supportive and Nutrition Services programs. During this decade, the minority participation rate for the Title III-B Supportive Services and Senior Centers program has dropped by 24.7 percent, from a high of 21.9 percent in fiscal year 1980 to a low of 16.5 percent in 1985. The harsh reality is that the minority participation rate has fallen every year during this decade except for 1982, when it remained unchanged.

A similar pattern exists for the Title III-C Nutrition Program for the Elderly. The minority participation rate has declined every year since 1980, except for 1983. Overall, the minority participation rate has dipped by 13.7 percent, from 19.0 percent in fiscal year 1980 to 16.4 percent in 1985.

Aged Blacks have been negatively affected. In fact, nearly 300,000 fewer Blacks received Title III-B Supportive Services in 1985 than in 1980. The aged Black participation rate has plummeted by 23.0 percent during this period, from 13.9 percent in 1980 to 10.7 percent in 1985.

NCBA calls upon the Subcommittee to include report language to promote career preparation training for minorities, especially at historically Black colleges and universities. This is essential to emphasize that career level education for minority group individuals is a high priority goal. It is also crucial to attract more minorities into the field of aging.

In conclusion, NCBA wishes to reaffirm its support for the funding levels that we have proposed. We believe that they are reasonable, realistic, and legislatively feasible. We urge the Subcommittee to adopt them.

Once again, we wish to thank the Subcommittee for the opportunity to testify. Now, we shall be glad to respond to any questions that you may have. Thank you.

STATEMENT OF LARRY HILL, STATE SENATOR FROM OREGON

Senator CHILES. I understand State Senator Hill is here now. Senator Hill, we would be delighted to hear from you now.

Mr. HILL. Thank you, Mr. Chairman.

Senator CHILES. I trust you have the Senate in Oregon running a little bit better than the one here?

Mr. HILL. Well, it is a smaller shop, so it is a little bit easier to take care of.

Senator CHILES. Are you all in session now?

Mr. HILL. We are in session. Yes; we will be in session until June. We are having a very good session. I believe we are going to have some significant legislation, reforming workers compensation and a number of other important pieces that we are dealing with.

Senator CHILES. Well, we look forward to hearing from Oregon. You have always had a progressive State and have taken a leadership role in a lot of the State legislation that you have passed there.

Mr. HILL. Thank you, sir.

Senator CHILES. Oregon and Florida I think can both be proud of their State legislatures.

Mr. HILL. Thank you, sir. We appreciate that.

Senator CHILES. I am a creature of the State legislature, having spent 12 years there, and I feel like in some ways I thought I was coming to the major leagues when I came up here. I found out that we are way behind in a lot of things that the States are doing.

We are delighted to have you here today.

Mr. HILL. I am here to speak specifically to an issue that is very important. As chair of the senate Labor Committee, I have come into knowledge that our State employment services system is in dire straits, and I have come to speak specifically to that particular problem because it is critical in delivering services to people in the State who have suffered unemployment.

As you probably know, we have suffered in the Pacific Northwest a severe dislocation of our wood products industry. We have had very high unemployment. We are doing much, much better now. The legislature has adopted economic reform proposals and gone out looking for investment and enhanced in-state investment, pulling ourselves up by our bootstraps. We have done very well, but we still have many people depending on employment services.

I would like to note for your information that I have actually two pieces of testimony. I am wearing two hats today. This is the first time I have testified before Congress, and it is fairly exciting for me. I am representing two different organizations: One, the Oregon State Senate and the Oregon Legislature; also, second, the National Conference of State Legislatures, because the States have a common interest in many areas, as you know, particularly in unemployment services. We all have a common interest in trying to see that our services remain intact.

Senator CHILES. Both of those statements in full will be introduced, so if you could digest them for us.

Mr. HILL. Very briefly, the situation that we have now is the dedicated fund which are collected by the Federal Funds, FUTA, of course go into an account that can only be used to provide employment services in the States and for no other purposes, administrative services.

The State and the Federal Government have a partnership. We collect money for the benefits, and you collect the money and distribute it for services. We have a feeling at the State level that the Federal end of the partnership has not been upheld.

In particular, there is actually a feeling of betrayal because we know those dollars cannot go anyplace else. They are dedicated dollars. They cannot go to the deficit. They cannot go to human services. They cannot go to defense. They cannot go anywhere. They can only go to pay for services at the State level in local unemployment offices for staffing, for staffing for the targeted jobs tax credit, for staffing for employment services, and they cannot go anywhere else.

Therefore, when we see those funds being withheld for no good reason that we can understand except perhaps to meet the Gramm-Rudman target, it just is very, very frustrating.

Senator CHILES. That is not the only place we do it, though.

Mr. HILL. I understand, sir.

Senator CHILES. Our airport trust funds, we collect money. Again, it is specifically supposed to be used for airports. Much of that money is held. It is a device that OMB and the administration use in effect supposedly on the deficit.

We do the same thing now with Medicare recipients. We have instructions out there to the Blue Cross/Blue Shield and the providers that they are delayed, holding bills for a certain number of days.

The administration has blatantly said, well, you do not pay the hardware store for 30 days. Why should we pay our bills. Even though these are senior citizens, even though the money is coming from them and employers under the deductions, we are going to withhold that money for a period of time.

You are exactly right. The same thing has been happening on the employment services.

Mr. HILL. I think that a better, a more fair way to target deficit reduction would be to target those discretionary items, not the items that come from the dedicated fund. If we could exempt some of those items that you have described, sir, including the FUDA money, I think we would have a more fair approach to deficit reduction because this does not contribute to reducing the deficit at all. It simply is shuffling figures on paper.

I would like to speak to one particular point. Secretary Brock of Labor has been reported as saying that no employers use the job service, and I would like to contradict that opinion. In Oregon, we have had 20,000 Oregon employers seeking placements on 100,000 jobs. We have a very heavily used system. Our employers use it. Eighty-six thousand job seekers are finding work through our employment services. We have to continue that to provide effective services for those employers.

There is a chart attached to my testimony, and this is the money we received from the Federal Government we received for those services. I am sure you have seen many similar charts, but from 1979 to 1986 we have suffered a reduction of almost $6 million. We have reduced services accordingly, and we have also doubled the workload for many of our people, literally doubled the workload for the staff that we have left.

Right now, the employment office in my hometown in the heart of my district is going to be closed because we do not have the money even though the money is sitting in the account here in the hands of——

Senator CHILES. Well, I am sure the Oregon Legislature is never inconsistent, but we have some inconsistencies here, and I will tell you one of them that is working right now. The House put $100 million on the supplemental for funding here. The Senate did not include that in the Senate supplemental.

We are on the floor now, but we were seeking a waiver under Gramm-Rudman-Hollings because the supplemental is above the budget targets for last year. We are seeking a waiver. That is a 60-vote margin. Yesterday we ended up with 52 votes, so we failed. It was a motion to reconsider and left pending. Today we are going to take it up. It does not look like there is any way that we can do it. There were only seven Republicans that voted for the waiver yesterday, less than there are on the Appropriations Committee, although all those members, you know, have what they are putting in there. So we are looking at that.

The same House that put $100 million in for the supplemental has cut inthe budget resolution for 1988 the services by $100 million. That is the Budget Committee as opposed to the Appropriation Committee. I am sure you have those same differences.

The Senate does not have that cut. The Senate has current services, but the net result is the question on whether there will be additional funds will be before the conference if we ever get the supplemental up.

We will also be at conference next week on the budget resolution, where they have a $100 million cut for 1988 and we have no cut for 1988.

Mr. HILL. I understand the difficulties.

Senator CHILES. I think the point that you make—I am chairman of the Budget Committee and continually concerned about these terrible deficits we have. I wear that hat in a different chair in this subcommittee, but to me service is like, where you are trying to create jobs, it is kind of foolish that you cut back on those. You are really shooting yourself in the foot to do that.

When that came up last year, I tried to raise those points, but to no avail. We could not get anybody to listen. Maybe we will be able to this time.

Mr. HILL. I hope to have an opportunity to talk today to Senator Hatfield, who is one of our own Senators.

Senator CHILES. Talk to Senator Packwood, too.

Mr. HILL. I definitely will try to, to perhaps contribute to the activity on the floor.

Senator CHILES. I think if some of your cohorts again in the National Association would kind of speak, because there was little or no understanding about this when it came up in the Appropriations Committee last year when they made this cut. When some of us tried to say, wait a minute, because I just heard from my State offices and knew a little bit more about some of the things it was going to do, I do not think anybody had done their homework, and no one seemed to understand it.

Mr. HILL. Just one last point, sir. The States are responding. Oregon is transmitting part of our benefit moneys that we have collected for operations. We are increasing the tax on employers for benefits to cover part of the cost of operations, and we are increasingly doing this, but they are being taxed twice. Employers are being taxed twice. Our employers are being taxed twice for those services. They do not like it, and they have a right to be upset about it. As well, the unemployed are suffering a reduction in services.

Senator CHILES. I agree with that. States do need to look at how these offices are working.

Mr. HILL. Absolutely, for efficiency.

Senator CHILES. As you know, some of them are not very efficient, while others are doing——

Mr. HILL. That is true. We have adopted an efficiency plan, and we have increased workloads extensively, and we are getting more bang for the buck.

Senator CHILES. I think we really needed that, because I have seen some that——

Mr. HILL. That is true, but at the same time our quality control is slipping because we cannot fund our quality control positions that really should be there. So by not funding those quality control positions, we lose more money.

But we are struggling with this, as you are struggling with your budget limitations. We are struggling at our level. The main thing, the frustrating thing is the money is there. It is dedicated. It cannot be used for any other purpose. It should be exempted from the Gramm-Rudman limit as a dedicated fund.

PREPARED STATEMENT

That is my primary message, and if the Appropriations Committee can possibly move toward the House position regarding these particular moneys in conference committee, I would represent the State of Oregon and NCSL is strongly urging you to please do so.

Senator CHILES. Thank you, Senator. We appreciate your testimony here today.

[The statement follows:]

STATEMENTS OF LARRY HILL

Mr. Chairman, Members of the Committee, my name is Larry Hill. I am a State Senator from Eugene Oregon, and chair the Oregon Senate Labor Committee. Today I represent not only Oregon but the interest of the National Conference of State Legislators in the funding of all state employment security agencies.

We want an effective agency to match qualified job seekers to employers' vacancies, to pay unemployment benefits promptly and correctly and to provide local labor market information for current and prospective industries. A surplus of over one billion dollars, building to over two billion dollars in 1988, is available in the administrative account derived from the employer paid Federal Unemployment Tax, but your reduced appropriations continue to limit our ability to use those funds. At a state level, I get complaints from the employer tax payer who wants his money's worth for his tax dollar and complaints from the job seekers who are getting less and less help from our local employment offices. My deep frustration is that the federal-state partnership founded 50 years ago is disintegrating before our very eyes. Why should employers continue to pay for services not delivered? Why should our citizens receive shoddy treatment due to extensive staff and equipment shortages?

In 1982 our funds were cut. We closed 13 local offices and over 50 itinerant points. From then on, each year has seen further cuts. Our employment agency must now rely on supplementing their reduced funds through state penalty and interest money and a diversion of state benefit trust fund tax dollars just to maintain the status quo and keep current offices open.

Employers get a double whammy and we still provide less than satisfactory service.

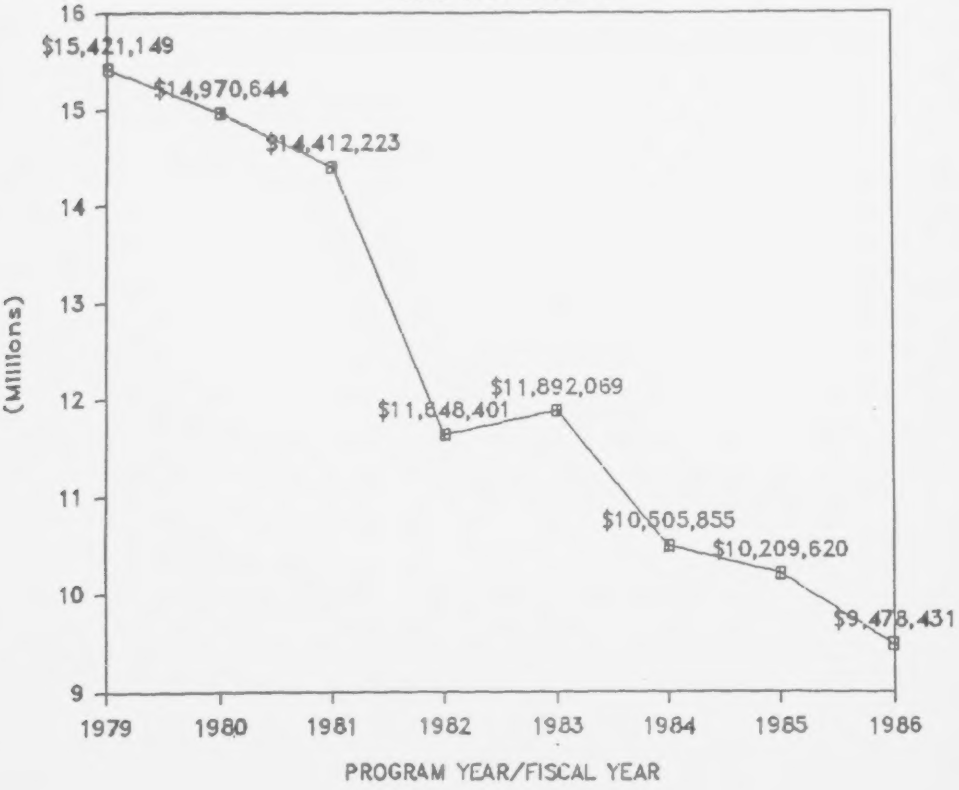
Let me now address the specifics of the FY88 proposed appropriations:

Employment Service (ES)

The administration proposes a $90M cut for this program. Secretary Brock has said, "No employers use the Job Service". As far as my state is concerned over 20,000 Oregon employers gave us over 100,000 job orders. This resulted in 86,000 job seekers finding work through our Employment Division. The Oregon experience is reflected in all states, and the Secretary was sadly misinformed. I urge you to appropriate at least the current level of $755M, adjusted for inflation, for the employment service. If you will refer to the graph enclosed with my testimony, you can see the dramatic reductions we have already experienced.

ES FUNDING LEVELS

USING 1986 DOLLARS



Another factor in the ES funding is the expectation you appear to have that we will operate additional programs with no funding. Targeted Jobs Tax Credit (TJTC) and Immigration Reform are two examples. There is a $30M item in the FY 88 budget for TJTC. I urge your support for this program. You have told employers there is a TJTC program. We are the ones who must tell them it isn't funded.

Immigration Reform has a role for the employment service, but again there are no funds available. We believe you have an obligation to include an FY88 budget item for this important new program.

Labor Market Information (LMI)

Another important function that is being negatively impacted by the reduction in funding is the Labor Market Information program. The state employment security agencies are the fountain-head of labor force and general economic information at the state and local area levels.

Accurate and timely labor market information is a vital link to the planning processes for an effective Job Training Program and a responsive Vocational Education program. Nation wide billions of dollars are being invested in these programs and without adequate planning data these funds could be badly misdirected and totally wasted.

In Oregon, we use Wagner-Peyser 7B dollars to fund local LMI. The level of this fund relies upon the entire ES appropriation (10% of all ES funds).

Unemployment Insurance (UI)

The positions used in processing unemployment insurance claims in Oregon have been reduced 21% from 1978 to 1987 with the same workload. In addition the federal allocation to pay for supplies, rent, utilities, etc. (NPS) has been grossly underfunded.

It is no wonder the Employment Division staff believes they are up against impossible odds in trying to provide quality service to Oregonians.

In order to make up the shortfall in NPS, tax positions have been left vacant, resulting in uncollected taxes. This reduces the trust fund level and thus impacts the federal budget since those state specific trust funds are included in the unified federal budget.

This last two years we used state money to fund five revenue agents. They collected more than 22 times their total salary, fringe benefits and NPS costs.

The administration proposes to cut appropriations for the unemployment insurance program by another $100 million which, as you know, is on the heels of a $144 million reduction in FY 87. This will cause further deterioration of program integrity which is vital to such an extensive benefit program. I urge you to fully fund the UI program.

In conclusion, we state legislators feel that Congress is retaining the appropriation authority over employer paid tax dollars, but by refusing to fully appropriate the funds, is dumping the responsibility for services on our backs. We have the choice of double taxing our own employers or letting the system fail.

DATA FOR OREGON EMPLOYMENT DIVISION

PY 1985 (7/85 thru 6/86)

21,476	Different employers listed openings (does not include private households.)
111,083	Openings listed.
86,396	Openings filled.

Openings range from professional (doctors, engineers, etc.) to farm labor to ditch diggers.

269,629 applicants were served. They represented an even wider range of skills than job openings did.

Openings were filled by:

25,483 females; 20,125 youth; 19,629 claimants
18,054 minorities;and 17,685 veterans.

Introduction

My name is Larry Hill. I am a member of the Oregon State Senate and Chairman of the Senate's Labor Committee. I am here today on behalf of the National Conference of State Legislatures to express our concern for adequate administrative funding for the Unemployment Insurance/Employment Service program, as well as other joint state-federal programs within the purview of this Committee.

As you know, the Unemployment Insurance program is based on a state-federal partnership in which state governments raise revenues for the provision of benefits, while the federal government collects revenue to finance administrative expenses of the program at all levels. The federal share is provided through the collection of a tax on employers (the 'FUTA' tax) which is deposited in the Employment Security Administration Account (ESAA), a dedicated trust fund. A formula then determines each state's allocation.

Unfortunately, because the ESAA trust fund is included in the unified federal budget, a positive balance in the fund is counted as a "paper offset" to the federal deficit. We are deeply concerned about the potential for underfunding UI/ES administration for the purpose of artificial deficit reduction. The budget approved last year for fiscal 1987 did precisely that, reducing administrative monies paid out of the trust account by $144 million.

Importance of Adequate UI/ES Funding

Mr. Chairman, I would like to impress upon you and the members of the Committee the vital importance of a supplemental appropriation to restore some of that funding. Without a supplemental appropriation, employment security agencies in many states around the nation face staff reductions, branch office closings, degradation of service, and curtailment of oversight activities. In a compromise agreement, the House included a partial restoration of UI/ES funding in their version of the supplemental; NCSL urges you and the Senate conferees to recede to the House position on this issue.

It is vitally important that a supplemental appropriation for FY '87 be approved, and that funding for FY '88 be maintained at least at the level of that originally approved for fiscal 1987 *plus* the supplemental. Regrettably, the House's FY '88 concurrent resolution fails this test, and it is our understanding that, at this time, the Senate's version also omits full funding of UI programs. Mr. Chairman, NCSL strongly recommends that UI receive more funding when you get to conference.

Consequences of Inadequate Funding

Bear in mind that UI benefits are an entitlement. Therefore, reductions in administrative funding cannot be matched by reductions in the number of people served. For that reason, administrative cutbacks necessarily imply a reduction in the *quality and availability* of services provided, with two particular consequences.

First, those who the program is intended to serve will be adversely affected. They will have to wait longer in lines in local offices, and in some cases travel farther to reach an agency office. They will face delays in processing claims, delays in benefit payments, and delays in eligibility appeals. Finally, they may be deprived of the opportunity for a job created by the Targeted Jobs Tax Credit approved by the Congress last year, simply because there isn't enough staff to handle the applications.

Secondly, inadequate funding for administrative expenses now may cost more in the long run, because of the resultant curtailment of oversight and quality control activities. Agencies will have to adopt higher thresholds for fraud prosecution, reduce efforts for investigation and overpayment recovery, and conduct fewer employer tax audits--inevitably leading to more delinquent and uncollected taxes.

Already, the consequences of last year's funding reduction for UI/ES administration are being felt around the nation. The U.S. Department of Labor has estimated that state agencies across the country will be forced to eliminate about 5,800 UI staff positions this year -- a reduction of more than 10%. According to a survey conducted by the Interstate Conference of Employment Security Agencies, eleven states plan to close a total of 94 full service and itinerant service facilities.

In my own state, **Oregon**, our employment service faces the closing of 10 branch offices on July 1. In **New York**, the Department of Labor expects a reduction in force of 661, and the closing of 16 Unemployment Insurance/Job Service offices. In **Iowa**, the cuts may force the closing of some rural offices, requiring some people to travel several counties to obtain service. In **Connecticut**, district offices are down to a bare minimum staff level, and 171 positions are now being subsidized by the state. In **Arkansas**, where the agency's funds have been reduced for the last five years, "intermittent", or temporary, employees are being used, and monitoring activities have been cut back. **Mississippi**, which has lost about 70 staff positions, reports delays in processing claims. These are just a few examples of the difficulties states are experiencing.

Clearly, the effect of inadequate administrative funding is to promote inefficiency and waste in our Unemployment Insurance programs. To expect an agency to maintain a level of service while reducing the resources available to it is to ask a great deal. To *increase* its responsibilities while reducing those resources is unreasonable. Yet this is exactly what has occured. Employment security agencies have been given new responsibilities without consideration to funding requirements for administering them. The Targeted Jobs Tax Credit program I refered to earlier is a good example. Also, the new immigration law imposes a great deal of additional administrative responsibility on ES agencies, without any additional funding. These new responsibilities underscore the importance of releasing adequate funds from the ESAA trust account.

Other Programs

I am sure that you are well aware that as state legislators we are concerned with other activities addressed by this subcommittee. NCSL has consistently urged the Congress and the Administration to place a high priority on funding for the means-tested entitlement and safety net programs. While the income-based programs such as medicaid and aid to families with dependent children are handled by other committees, you deal directly with the discretionary side of support for those in our society who need the help of federal and state governments.

Health & Human Services

We are pleased to see that the concurrent budget resolution for 1988 protects these activities, and in fact, provides for certain expansions.

Programs such as the Social Services Block Grant and other health-related block grants are essential to combatting problems such as infant mortality. States continue to deal with such national issues as immigration and refugee populations who are in need of a support network and services. To ensure a strong future we must continue to devote resources to initiatives such as child nutrition and other community-based programs. NCSL supports efforts to increase funding for AIDS education, treatment, prevention, and research activities.

Education

NCSL continues to acknowledge an important federal role in assisting states in maintaining strong educational systems. This is in the national interest for our defense, for the development of a strong economy, and for the stability of a fair and productive society.

In keeping with the drive to make our nation more competitive in world markets we must provide optimal opportunities to educate our youth. Recent budget action by the Senate shows your commitment to programs such as compensatory education, employment and training, and student financial aid. Support should also be continued for handicapped education and child welfare services, to give all in our society a chance to progress and succeed. Finally, education reform and excellence initiatives by states and localities will be greatly enhanced by your continued support of the Education Block Grant.

* * *

Again, we applaud your efforts to deal with the federal deficit, and at the same time, to provide resources where they are truly needed. We ask you to follow through on these key proposals included in the budget resolution in your subcommittee deliberations and mark-up.

STATEMENT OF RUTH M. BERKEY, NATIONAL PROGRAM DIRECTOR, NATIONAL YOUTH SPORTS PROGRAM

ACCOMPANIED BY:

WALTER REED, ATHLETICS DIRECTOR AND PROJECT ADMINISTRATOR, JACKSON STATE UNIVERSITY

EDDIE PAYTON, HEAD GOLF COACH, JACKSON STATE UNIVERSITY

Senator CHILES. Now we will hear from Ruth Berkey of the National Youth Sports Program.

Ms. BERKEY. Good morning, Senator Chiles. My name is Ruth Berkey. I am presently an assistant executive director with the National Collegiate Athletic Associate and since 1982 have served as the national program director for the National Youth Sports Program [NYSP].

I am delighted to be here today, and I would also like to introduce Walter Reed from Jackson State University, the athletics director and project administrator from Jackson State University, and Eddie Payton, former professional football player with the Cleveland Browns, the Minnesota Vikings, and the Detroit Lions, but more importantly a former NYSP participant. Eddie is presently the golf coach at Jackson State University.

PREPARED STATEMENT

We are here this morning to testify on behalf of the National Youth Sports Program for fiscal year 1988 and to request $9 million of your support for what we believe is a very important program. It deserves it on its merits because it serves very importantly economically disadvantaged young people.

[The statement follows:]

STATEMENT OF RUTH M. BERKEY

Mr. Chairman and members of the Subcommittee, my name is Ruth M. Berkey. I am an Assistant Executive Director of the National Collegiate Athletic Association ("NCAA") and, since 1982, have served as National Program Director of the National Youth Sports Program ("NYSP"). Also with me is Eddie Payton, Head Golf Coach at Jackson State University, former professional football player with the Detroit Lions, Minnesota Vikings, and Cleveland Browns, and a former NYSP participant. I appreciate this opportunity to testify in support of a $9 million appropriation for the FY 1988 NYSP.

We recognize that this Subcommittee must work within severe budgetary constraints in allocating funds among many deserving programs. Nonetheless, in view of the dramatic cost increases the NYSP now faces, the NYSP's demonstrated record of success, and its ability to deliver $3 of high-quality services to needy youngsters for each federal dollar appropriated, we believe that the NYSP merits increased federal support.

Each summer, the NYSP brings more than 50,000 disadvantaged boys and girls, ages 10-16, onto college campuses. There they are provided a rigorous program of skill instruction and competition in a variety of sports, including the lifetime sport of swimming. Each participant receives a free daily USDA-approved meal or snack and a free medical examination and follow-up. In 1986, 53,840 low-income youngsters participated in NYSP projects at 136 colleges and universities in 115 cities in 42 states. Over two million meals and snacks were served and 56,396 medical examinations were performed.

The NYSP design philosophy recognizes that body and mind must be nurtured together. An enrichment program therefore is a central part of each NYSP project. Participants receive instruction in such topics as drug and alcohol abuse prevention, health and nutrition, educational and job opportunities, and teen pregnancy and teen suicide prevention. This summer, many participating institutions also will add AIDS education.

In its 18 years of operation, the NYSP has enriched the lives of nearly 800,000 youngsters, many of whom live in the poorest neighborhoods in our nation. Special efforts are made to target "high risk" youth for participation in the program. For most participants, the NYSP is their first exposure to a college campus and gives them access not only to some of the finest athletic facilities in the world, but also to campus educational and cultural facilities and events.

A significant side benefit of the NYSP is its provision of summer employment for many residents of poverty target areas. In 1986, the NYSP provided 3,797 such employment opportunities.

All NYSP projects are reviewed annually in a process that includes an on-site review and a written evaluation. The HHS Inspector General found that "[t]he NCAA provides strong accountability for [the] NYSP through annual on-site evaluations, periodic financial and statistical reporting, and several audits."

Since its inception in 1969, the NCAA has administered the NYSP without charge for its services. I serve as NYSP National Program Director and am assisted by others on the NCAA staff. The NCAA also donates office space and supplies and pays for NYSP-related legal fees and telephone and postage expenses. The NCAA pays for travel costs of NYSP Committee members, who volunteer their services; travel and per diem expenses of NYSP project personnel and NYSP evaluators; and professional fees of NYSP evaluators.

The NCAA is an association of nearly 1,000 colleges, universities, and affiliated organizations established to govern intercollegiate athletics and to serve its member institutions and college student-athletes. The disadvantaged youngsters who participate in the NYSP therefore are not part of the population the NCAA exists to serve and the program is not one for which NCAA funds -- which are those of its member institutions -- normally would be spent. The NCAA donates its assistance to the NYSP as a community service. In 1987, the NCAA will contribute nearly $335,000 to the NYSP.

Participating institutions donate educational and sports facilities of the highest quality to the NYSP, as well as equipment and the services of a project administrator. Last year, these contributions were valued at more than $9 million. Businesses and state and local governments contributed an additional $3.6 million in such forms as grants, equipment and clothing, and project awards. By building upon the essential core of federal support, the NYSP was able to serve 53,840 disadvantaged participants in 1986 with a federal expenditure of only $109 per child.

No federal funds are allocated to the NCAA or to participating institutions for overhead. The federal funds appropriated go directly into providing services that benefit the low-income youngsters.

Each year since 1976, the NYSP has received about $6 million in federal support (currently as a grant from the HHS Office of Community Services ("OCS"), Family Support Administration, to the NCAA as a Community Services Block Grant discretionary program). In FY 1986, the NYSP was cut 4.3% as part of the Gramm-Rudman-Hollings across-the-board cut. In real dollars, however, the 1987 federal contribution of $5.866 million is just over half what was provided in 1976 ($6 million x 0.508 BLS Consumer Price Index deflator = $3.048 million).

While federal funding has held steady, operating costs have sharply increased. From 1984 to 1985, for example, NYSP food costs jumped 1400% -- from $31,000 to $495,000. Transportation and insurance costs also have risen sharply.

The NCAA has worked hard to identify and attract other sources of funding. Since 1976, the NCAA contribution has increased more than tenfold and locally, many participating institutions have increased their contributions to the program and area businesses have given added support and donations.

Until recently, it has been possible to maintain the NYSP at past levels. Now, sharply increasing costs are beginning to take their toll. Three years ago, salary ceilings were instituted. The winter segment of the program has been discontinued. Not only has the NYSP had to turn away qualified institutions anxious to offer the program, but last year, the number of projects funded fell from 141 to 136 and the total number of participants served fell from 56,986 to 53,840. Many NYSP projects no longer can serve hot meals each day, which for many participants was their only hot meal of the day; youngsters now receive USDA-approved box lunches. Increasing transportation costs have limited the NYSP's ability to serve needy high risk youngsters in outlying and rural areas who want to participate in the program.

Not only is the NYSP an effective and worthy current use of federal funds, it also is a wise long-term investment in our nation's youth. Moreover, it is a tested vehicle for dealing successfully with current issues of national concern. We are not alone in our view that the NYSP is a high-quality program that works. Jerrold Speers, former OCS acting director, described the NYSP last year as a program of "high merit and great urgency" that could "contribute significantly to the timely solution of the pressing problems in the areas addressed."

For all of these reasons, we request that you recommend an appropriation of $9 million for the NYSP in FY 1988. The increase of just over $3 million would restore about half the amount lost to inflation since 1976, and would ensure the continued viability of the NYSP and its ability to reach out to serve needy youngsters.

Thank you very much for the opportunity to testify this morning.

STATEMENT OF WALTER REED

Mr. REED. Mr. Chairman, I would like to talk about some of the offerings of the National Youth Sports Program. One of the things that the National Youth Sports Program does for the over 50,000 youths that it serves annually is that we provide a free medical examination which goes beyond the normal physical examination that one would expect to get in a program of this nature. One of the key components is that we check for sickle cell and we also do followup.

One of the other things that the program provides in its requirement is that we provide a hot meal for each participant, and we provide a snack. In my particular setting, in a city of over 270,000 citizens with no organized recreational program, this is the only organized type of program that we have for the youth ages 10 through 16 in the area. Over 70 percent of the kids receive their only hot balanced meal through our program while it is operating.

We also have instruction on drug abuse. We have instruction on alcohol abuse. We actually have confirmed alcoholics come in and talk with our kids. We have the local police department come in and actually let the kids see what the drugs look like; therefore, if someone approaches them about the drugs, they can recognize it from that point of view.

We also talk about and have the State Health Department come in and discuss teen pregnancy, because as we found out in the State of Mississippi, a high percentage of our young ladies that produce babies out of wedlock are between the ages of 14 and 16. So we figured if we can get them at that point and deal with it that maybe it would help some.

One of the outcomes of this is that the local school system in the Jackson Public Schools has now included in its curriculum a session on teen pregnancy, and I think that would be a great thing for the State of Mississippi.

We also bring in people from the local employment commission and the State employment commission to talk to then about job opportunities and job requirements. We talk about personal hygiene and other things.

So that is the sort of thing that we do in the program.

STATEMENT OF EDDIE PAYTON

Mr. PAYTON. Mr. Chairman, in conclusion to what has already been said, as a former participant and as a volunteer counselor now, no joy that I received in my 9 years of professional football-playing experience rivals the joy I receive each summer in having to work with these young people through the NYSP program. I respectfully ask you to ask yourself where would you be today if someone had not taken an interest, an early interest, in your guidance and direction? Do we not risk a little today for our youth of tomorrow, or do we risk a lot more when the youth of today become our leaders of tomorrow?

Thank you.

Senator CHILES. Thank you very much. We appreciate your testimony. I think what you are talking about with those women at those early ages is tremendously important. I hope you are also talking to young men, because those things do not happen by themselves.

Seriously, I think one of the things that we are finding out, and we have some of our fine athletes in Florida who are going to the high schools and where the young men will be, trying to convince them that is not necessarily a mark of manhood to see how many people that you can make pregnant. There are a lot of other ways that you can prove your virility or that you are a man besides that, and I think that is something that we really have to work on.

I am delighted to see you all here, and I appreciate the efforts that you are making.

STATEMENT OF MELVIN STERN, M.D., NATIONAL HEAD INJURY FOUNDATION

Senator CHILES. Now we will hear from Dr. Melvin Stern of the National Head Injury Foundation.

Dr. STERN. Good morning, Mr. Chairman. Thank you for the opportunity to testify before you today. I have been asked to stand in for Marilyn Price Spivack, the executive director of the National Head Injury Foundation, which is today sponsoring a conference of trial attorneys on the issue of head injury.

By way of introduction, I am Melvin Stern, a father, husband and practicing pediatrician and member of the National Head Injury Foundation.

Even though we tend to focus on the head-injured youngster, we must not forget about the head-injured family. Jenny is the one who was hit by the truck. The rest of us were hit by everything that followed.

Each year some 5 million youngsters sustain head injuries, and 250,000 require hospitalization. Fifteen thousand of these are extended hospitalizations. That means there are more than 250,000 families like the Sterns devastated by head trauma each year.

Permit me to briefly describe the events involved in Jenny's devastating accident. Jenny was a 7-year-old at the time of the accident, and she was a charming, vivacious, and articulate youngster, a youngster who enjoyed her family, school activities and her rural lifestyle. Since age 3 she had been active in showing dairy cattle and was looking forward to showing her own animal that summer.

Jennifer, dressed in a Brownie uniform, was on her way to the school bus stop when she was struck by a speeding pickup truck. Almost immediately the State Police helicopter arrived and evacuated her to the pediatric shock trauma unit at Johns Hopkins Hospital. Forty minutes after the accident she had already received one unit of blood, had surgery performed on her chest and was on a mechanical ventilator.

There is no doubt that without the rapid evacuation, immediate, intensive and very skilled surgical and medical attention, Jenny would not have survived at all. She would have been one of the 4,000 youngsters who annually succomb to the effects of brain trauma.

It is very clear, especially in this region, that the emergency medical systems and shock trauma centers are doing an outstanding job.

She remained in intensive care for the next 6 weeks. Following 3 months of acute hospitalization, Jenny was transferred to the John F. Kennedy Institute Pediatric Rehabilitation Unit for the beginning of her lifelong rehabilitation program. In truth, what was beginning was a rehabilitation program for the entire family whose life had been irrevocably changed.

There are several very significant issues which stand out. During Jenny's 6 months of hospitalization, the remainder of the family was placed in suspended animation. In all due candor, as a professional I was not prepared for the 3-year journey out of the deepest psychological hole I ever hope to encounter. In retrospect, the entire family groped their way, individually and collectively, out of this giant hole. Unfortunately, there are precious few well-trained individuals who are available to assist with this process.

The second issue of note is the continuation of the rehabilitation program following discharge from the acute facility. This turned out to be both frustrating and at times an adversarial endeavor. For example, the local school had recommended that Jenny be provided with therapy services. However, they then informed me that services would be delayed for 6 weeks due to a scheduling conflict. When the mandate of Public Law 94–142 was pointed out, the scheduling conflict was resolved in a matter of hours.

Third, even though many services are mandated, they are simply not available. Jenny is not here today because she is attending school in Southern California. Despite the presence of major academic and medical centers in this region, the quality integrated services required by Jenny are not readily available.

The last issue noteworthy of mention this morning is that of finances. The cost of Jenny's acute care hospitalization was approximately $110,000. The cost of the rehabilitation has been over a quarter of a million dollars to date.

Jenny's little body was literally scraped off the pavement and placed in a battle-ready system which kept her alive. Jenny is only one of 250,000 youngsters encountering this system, and if we then include the families, there are somewhere close to 1 million constituents involved in major head injuries each year.

As the emergency medical systems around the country improve, this number will surely increase. The urgent need, therefore, is threefold: establish training facilities and programs to generate professionals conversant with the problems of patients and families surviving catastrophic brain injury; establish regional centers for long-term rehabilitation so that very many Jennys do not have to travel 3,000 miles to receive quality care; and finally, recognize the very real financial requirements of the rehabilitation process.

The brain injured youngster is different, different from the cerebral palsy, mentally retarded or congenitally handicapped. Let us maximize their potential, not simply provide them with a minimum. We as a society have scraped these youngsters off the streets. Let us finish the job and permit them and their families to resume their lives in as productive and dignified a manner as is possible.

The written testimony contains our specific recommendations and concerns relative to fiscal year 1988 appropriations. Thank you.

PREPARED STATEMENT

Senator CHILES. Thank you, Doctor. We appreciate your testimony. I have been hearing an awful lot from parents lately about the need for this early intervention and the need to be able to just to find out where the services are and going from one county or school district to the other and finding out the services are totally different, as you say, even though they are supposed to be provided.

We appreciate your testimony here today.

[The statement follows:]

STATEMENT OF MELVIN STERN

Mr. Chairman and members of the Subcommittee, the National Head Injury Foundation, Inc. (NHIF) is a growing organization of 30 State Associations, 7 Affiliates, 350 support groups and 17,000 members (survivors, families and concerned professionals) providing support, information, education and advocacy for individuals suffering brain damage after head injuries. Created in 1980 to improve the quality of life for head injured survivors and their families, the NHIF has made public awareness and education one of its critical goals.

On May 14, 1985 the NHIF entered into a cooperative agreement with Office of Special Education and Rehabilitative Services (OSERS). That Agreement has become a valuable working document that is already producing an increased awareness and interest in research, training and dissemination of information at the Federal and State levels. At this time, seven NHIF State Associations have signed similar agreements and 23 states are working closely with their Department of Rehabilitation to implement head injury registries, needs assessments, training of counselors and special educators, and to study and plan for appropriate implementing and funding of a coordinated system of service and case management. These same states are also working with members of the state legislatures for necessary authorizations and appropriations.

It is estimated that each year 400,000-500,000 Americans are admitted to hospitals following traumatic head injuries which cause brain damage. The majority of victims are under age 35. Two-thirds are male. The primary cause of head injuries is motor vehicle accidents. Forty to fifty thousand (10%) persons are left annually with severe and complex disabilities which affect them physically, intellectually and emotionally.

These patients require a multitude of services over extended periods of time-often a lifetime-illustrating the need for the establishment of a well-coordinated system of care from the onset of trauma to the delivery of support systems in the community. Families of these patients also need specific attention, services and economic relief from the catastrophic financial burdens.

The majority of head trauma victims who sustain a so-called "mild" head injury are discharged from hospitals after brief evaluations, with satisfactory or good prognosis. However, recent studies have proven that victims of mild head injuries may experience cognitive impairments, memory loss, personality changes, extreme headaches and/or fatigue, as well as other impairments which interfere with and disrupt their lives. Studies also reveal that these individuals often fail in their attempts to return to their previous jobs or academic programs. These impairments may be intensified over time when they are ignored and overlooked by professionals, causing increased disability and despair.

Whether an individual is mildly, moderately or severely head injured, his/her need for medical, rehabilitation and community-based services cannot be ignored any longer. Currently, only a small fraction of the head injured population receives appropriate care and services, that would provide the opportunity to return to an optimum level of function. The NHIF can only estimate that one in twenty may be fortunate to have the private funding to access the system of head injury care available. Oftentimes that system, too, may be fragmented and spread across the country causing further stress and burden to both patient and family. Tens of thousands of our young citizens are denied the access to appropriate medical care and rehabilitation services; therefore, they are denied the opportunity to regain function and quality of life. It is common that their caretakers and family members bear the enormous burden of emotional turmoil, economic loss, dysfunction of siblings, marital break-up and loss of jobs.

In the DOT HS 807 052 Final Report, June 1986,-"A Preliminary Study of Head and Neck Trauma of Motor Vehicle Crashes and Their Consequences", Vol. 1, the following statement was made-"Head injury outcome is important not only to the patient and his significant others, but also to society. It is estimated that injury costs $96 billion a year in direct and indirect costs. The events have far reaching financial, emotional, and societal ramifications for the patient and the society or system of which he/she is a part. Society should be informed of the everlasting affect of head injury."

The NHIF has taken on the responsibility of informing society, but we cannot do it without the assistance and support of the U.S. Congress and the Administration. Therefore, the NHIF has developed the following Legislative Agenda for 1987 that focuses on the urgent needs of survivors, families and the professionals who are needed to provide specific treatments and rehabilitation services. Therefore, the NHIF makes the following requests:

1) We request that $30 million be newly appropriated and earmarked for the following purposes through existing authorizations.

A) We request that $10 million be appropriated to agencies under Health and Human Services and the Dept. of Special Education and Rehabilitative Services specifically to develop basic and applied research in rehabilitation and technology, and required data collection, while focusing on incidence, prevalence, outcome and needs, training, education, and model demonstration programs, that impact upon functional outcome to enhance return to home, school, work and community.

B) We request that $10 million to be appropriated to agencies under the Department of Health and Human Services for the development of prevention, research technology, surveillance programs, and strategies to broaden the dissemination of education to the general public.

C) We request that $10 million to be appropriated to the Department of Transportation for the Division of Injury Epidemiology and Control Center for Environmental Health Centers for Disease Control. Efforts must be intensified, and funding new programs continued, to control and eliminate the cause and incidence of all injuries.

2) The National Head Injury Foundation is requesting the establishment of a federal

head injury commission or other mechanism to develop needed recommendations and strategies which will foster and promote the following:

A) to establish traumatic head injury as a category of disability in order to promote epidemiology and prevalence studies so that training, programs, and services may be designed and implemented to serve the population, and in order to establish eligibility criteria so that head injured persons may access needed services;

B) a well-coordinated national data base system for traumatic brain injury (TBI) that will address epidemiology research, neural recovery, acute medical management and rehabilitation, extended rehabilitation services, and needs assessment for community re-entry support services;

C) training programs for physicans, nurses and allied health professionals in the medical care and rehabilitation of survivors of TBI;

D) a system of care from acute medical management to rehabilitation leading to the survivor's return to optimal function;

E) a mechanism to coordinate the activities of all involved federal agencies in that system of care;

F) an interagency collaboration fostering research in neuroscience, biotechnology, rehabilitation technology, pharmacology, behavioral sciences and educational/vocational methodologies for this population;

G) a more effective certification of both public and private funding mechanisms which currently present major obstacles in successful rehabilitation and habilitation;

H) the establishment of model community-based support systems required to achieve the goal of re-entry to home, school, community and workplace;

I) the implementation of prevention strategies that will prevent TBI and reduce disability caused by TBI;

J) the creation of a public education program which will lead to an understanding of the causes of TBI, the nature of the disabilities caused by TBI, and the overwhelming costs of these injuries to the individual, family and to society;

K) the recognition of the financial and emotional impact of TBI on caregivers and families and methods to reduce this stress within the family unit;

L) the removal of federal disincentives that are obstacles in the path of successful re-entry efforts.

3) We request support of NHIF recommendations for appropriations for the following programs that will impact upon the lives of those who sustain head injuries, and all others who are disabled by injury or disease:

A) Section 110 Rehabilitation State Grants: $1,409.1 million

State Vocational Rehabilitation Agencies are only able to serve approximately one out of every twenty eligible persons with disabilities. In 1986 and 87, persons with head injuries are now becoming identified and requesting services. This level of appropriation must be met to help meet the goals of the NHIF/OSERS agreement which promotes service delivery.

B) Supported Employment Services: $26.47 million

Established in 1986, the purpose of the Supported Employment Services for Individuals with Severe Handicaps, Part C of Title VI of the Rehabilitation Act is to assist State Rehabilitation Agencies in establishing collaborative efforts with other public and private organizations to provide opportunities for placement for persons with severe disabilities in "supported employment." It is critical that this new initiative be funded fully, as it is a needed program to give persons who are severely disabled by head injury the opportunity to achieve employment in integrated community settings. The NHIF also supports the release of monies for FY 1987, $22.1 million, as appropriated by Congress for supported employment initiatives.

C) Rehabilitation Training: $33 million

Rehabilitation training grants are critical to ensure that there will be adequately skilled personnel available to provide rehabilitation services to persons with head injuries and other disabilities.

D) Special Demonstration Programs, Section 311, Rehabilitation Act: $27.4 million

1986 amendments to the Rehabilitation Act specify that $9.52 million of FY 1988 authorization amount shall be used for demonstration projects for supported employment and that $475,830 be utilized for developing, expanding and disseminating model statewide transitional planning services for youth with severe disabilities. The NHIF would suggest new monies be appropriated under this program, as the response to this program under 1986 RSA's requests for proposals was overwhelming. Fifty-four proposals were submitted and only 4 proposals could be funded. The need for extended rehabilitation programs bridging the gap from hospitalization to community must be created for severely head injured adolescents and adults.

E) Comprehensive State Services for Independent Living: $12.31 million

These programs are important to the NHIF, as numerous studies clearly show that wide-range residual problems affecting mobility, cognition, memory, speech, vision, hearing, perception, personality, as well as loss of previously learned skills, have significant impact on the individual's ability to live independently. NHIF would encourage Congress to commit to the establishment and funding of an independent living service delivery system that would enable disabled persons to obtain their optimum level of function-thereby decreasing their dependence and increasing their productivity.

F) Centers for Independent Living: $25.75 million

Currently 40,000 persons are served in 125 Federally funded grant recipient programs. The funding increase will allow for 10 new centers. New Part B grants give priority to geographic areas in State which are currently not served or underserved by independent living centers. The NHIF can document that there is a dearth of such needed programs for severely head injured young and older adults across the country. Families bear an incredible economic and emotional burden and often a caregiver must give up a job or career in order to provide lifelong care and supervision-adding further to the loss of productivity to society.

G) National Institute on Disability and Rehabilitation Research: $52 million

The increase of 7% over the 1987 level would enable the Institute to fund about the same number of new field initiated and innovative research grants as FY 84 & 85 and meet the level of 50 new grants established by the appropriation committee. In light of the impact of needs in research and training, systems of model programs and a national data system required for persons with TBI, the NHIF would request Congress to add new monies earmarked for this urgent initiative and priority area.

H) Education of Children with Handicaps, State and Local Grants: $2,109.12 million

Congress should strongly consider the return of federal funding support of 15% to fulfill the congressional mandate of expanding the age range and scope of services without placing unreasonable demands on state and local levels. Parents of head injured children can testify to the enormous void in educational services available. The NHIF has requested OSEP and State Special Education agencies to indentify head injured children and adolescents and to survey their needs.

I) Special Education Personnel Development: $74.5 million

The NHIF has implemented its own Special Education Task Force for head injured children and youth. We request this level funding to provide training for special education and related services professionals who have requested specific training to meet the needs of traumatically head injured children and youth.

J) National Institute of Neurological and Communicative Disorders and Stroke: $630 million

Stable growth for research in the neurological sciences is critical if medical researchers are to keep pace with the opportunities which technology is making possible. The short-term savings which would be derived from a 26 percent drop in the number of new grant awards must be weighed against long-term human and economic costs. Major research initiatives which might have to be reduced include studying: 1) the efficacy of two drugs (Mannitol and Tham) in reducing the complications following head injury; 2) the relationship of the neurotransmitter gama amino butyric acid to antiepileptic drug mechanism; and the relationship of where brain damage occurs to subsequent language and cognitive impairment. The FY 1988 NHIF recommendation would enable the Institute to maintain stable growth of its research grant portfolio.

K) National Institute of Mental Health and Research Training: $330 million (Includes AIDS research funding)

Although the NHIF supports appropriation for AID research funding, we would hasten to remind Members of Congress that traumatic head injuries cause lifelong disabilities each year. We can no longer ignore the mental health needs of head injured people and their families. Behavioral and psychological deficits are proven to be the major factor in the long-term disabilities of traumatically head injured persons. Up until now, there has been no recognition in the National Mental Health, Research and Training Institute, therefore, there is no research or training agenda. The NHIF urges the appropriate Congressional committees to request of the Institute of Mental Health, Research and Training to: a) assess the mental health service needs and delivery systems for traumatic injured patients and their families; b) to investigate the efficacy and appropriateness of current mental health services; c) to investigate efficacy and appropriateness of current mental health treatments, in particular research of psychopharmacologic approaches to the management of cognitive, psychological and behavioral deficits after traumatic head injuries; d) to investigate current models of cognitive behavior, psychosocial training programs; e) to investigate needs and effectiveness of family mental health treatment approaches.

To continue to ignore this tremendous need will result in lifetime disabilities which cost this country billions of dollars and incalculable human suffering.

L) Developmental Disabilities, State Grant: $62.2 million

The NHIF recommendation is a 10% increase over the FY 1987 appropriation, an amount necessary to bring the program to a funding level commensurate with its mandated responsibilities. The majority of head injured persons are between 15-25 years of age. The incidence of injuries amongst children is estimated at one million annually-average incidence ranges from 190/220 per 100,000. Yet, many children are not identified and are lost in the system. Developmental disabilities can contribute greatly to the planning, evaluation, coordination and advocacy for this population. We are particularly concerned with activities which focus on case management, community living and employment.

As the 100th Congress begins, we are asking your assistance in meeting the needs of head injury survivors for increased programs and services. The wisdom and far-sighted decisions of past Congresses have made significant changes in the lives of those who are disabled and chronically ill. Today, we need your legislative mandates to improve the quality of life for the one-half million persons who sustain head injuries each year. The 100th Congress is our hope for the future of our loved ones.

STATISTICS OF TRAUMATIC HEAD INJURY

1) Trauma - major cause of death and disability under age 35.
2a) Two-thirds of all victims between ages of 15-25.
b) Male to female ratio of injury - 2:1
3) 200/100,000 head injuries a year; approximately 50,000 left with severe disabilities.
4) Trauma - greatest threat to life in childhood ages 0-14; head trauma accounts for about 16% of pediatric hospital admissions.

5) An estimated 1 million children sustain head injuries annually, including those treated in emergency rooms.

6) 25-40% of abused children will suffer a head injury.

7) 50% of battered children surviving a cerebral injury suffer permanent neurological, intellectual and psychological impairment.

8) Average annual incidence rate of pediatric head injury ranges from 190-220 per 100,000 including hospital admissions and fatalities which occur before child reaches hospital.

STATEMENT OF JOAN T. BARKER, PRESIDENT, NATIONAL REHABILITATION ASSOCIATION

Senator BURDICK [presiding]. Joan Barker, president of the National Rehabilitation Association.

Welcome to the committee.

Ms. BARKER. Thank you, Senator Burdick. I would like to thank Senator Chiles and other members of the subcommittee for the privilege of being here today to testify. I represent the National Rehabilitation Association, an organization whose purpose is solely to advance rehabilitation for persons with disabilities.

My written testimony today primarily addresses programs under the Rehabilitation Act. However, the National Rehabilitation Association is also supportive of other Federal programs which assist persons with disabilities in their efforts toward self-sufficiency.

In the written testimony we have submitted, you will find that we strongly recommend the authorization levels for the basic State Vocational Rehabilitation Services Program, for comprehensive services for independent living, for rehabilitation research, for rehabilitation training, for supported employment services, for persons with severe disability and for projects with industry.

Rather than reiterate the details we have covered in writing, I would like to explain in a practical way why these appropriations are a wise investment for America.

A significant portion of the Nation's population, an estimated 36 million individuals, are persons with mental and physical disabilities. The National Center for Health Statistics tell us that 22 million are disabled to an extent that severely limits their ability to function. This number continues to grow at an annual rate of 500,000.

As the median age in our country continues to rise, many of us will live to personally experience disability, while many others have known disability from birth.

Persons with disabilities continue to be the most unemployed, underemployed and the poorest citizens in this Nation. These vulnerable citizens are likely to remain dependent users of expensive Government services in the absence of rehabilitative intervention.

In fact, Social Security actuary tables document that an unemployed age 35 male who is disabled will draw $176,000 in Government payment over an average lifetime. This does not even begin to document the other benefits that become mandatory when a person with a disability is left unattended and their condition exacerbated. It is common to find a person who has a multiple disability that stems from a single disability wherein rehabilitation would have been likely at an early stage but is now more difficult and more expensive.

When institutionalization is required, our Government encounters expensive per diems plus medical services and a situation that is almost impossible to reverse. We cannot document all that would be spent without rehabilitation and, therefore, what dollars are spared; but I can tell you from experience that the amount is very significant.

I expect Congress to soon realize the potential of independent living and supported employment in this regard and to expand these programs substantially. We can document that persons who are rehabilitated return significant dividends to our Nation's taxpayers. Of course, the most significant contribution is a life that is self-sufficient and productive, but on both counts, financial and personal, few, if any, programs funded by the Federal Government consistently return so many benefits to every segment of society.

In closing, I would like to remind you that 67 years of services have proven the value of this unique program which is tailored to meet individual needs of any eligible person with any type of disability. It is an investment that yields tax dollars, productive citizens and an inner strength for our country.

PREPARED STATEMENT

The National Rehabilitation Association would sincerely like to thank you for your past and your continued support. Much remains to be done, and we hope to continue to earn your respect and confidence as we work for the rehabilitation of every person with every type of disability.

Thank you.

Senator BURDICK. Thank you. A very fine statement.

[The statement follows:]

STATEMENT OF JOAN T. BARKER

Mr. Chairman, Members of the Subcommittee, I am here today representing the National Rehabilitation Association, an organization whose purpose is solely to advance rehabilitation for persons with disabilities.

I extend the sincere appreciation of the nearly 17,000 members of the National Rehabilitation Association and its seven divisions -- the Job Placement Division, the National Association Rehabilitation Instructors, the National Association of Rehabilitation Secretaries, the National Rehabilitation Administration Association, the National Association for Independent Living, the National Rehabilitation Counseling Association, and the Vocational Evaluation and Work Adjustment Association -- for giving us the opportunity to present our views. Although I will primarily address programs under the Rehabilitation Act of 1973, we are also supportive of Federal Programs which assist persons with disabilities in their efforts toward self-sufficiency. The Rehabilitation Act of 1973, as amended, is one of the most complete and well-balanced pieces of legislation in the human services field. This program of Rehabilitation Services is a cornerstone in the governmental effort, at the Federal, state, and private sector levels, to assist Americans with disabilities in their efforts to achieve meaningful employment and self-sufficiency.

In the Fall of 1986, the Rehabilitation Act was amended (1) to require State Rehabilitation Agencies to provide Rehabilitation Engineering Services, (2) to assist State Rehabilitation Agencies in the establishment of Supported Employment Service Delivery Programs in each State, and (3) by other changes which, in conjunction with scarce resources, place more pressure on an already-overburdened service delivery system.

People with mental and physical disabilities comprise a significant portion of the Nation's population - an estimated 36 million individuals. According to the National Center for Health Statistics, approximately 22 million individuals are disabled in such a way as to chronically limit their ability to function.

The size of the disabled population is not static, but continues to grow -- through accidents, injuries, illnesses, and birth defects -- at an estimated rate of 500,000 annually.

The Rehabilitation Program signifies the Nation's recognition of its responsibility to provide disabled citizens with the opportunity to be a part of the mainstream of life as full participants.

Our Nation's past investments in this program has returned significant dividends to our Nation's taxpayers, and more importantly, to the persons with disabilities who receive rehabilitation services. Few, if any, programs funded by the Federal government consistently return so many benefits, both financial and personal, to all segments of our society.

The NRA's recommended appropriations for programs authorized in the Rehabilitation Act, as amended, are as follows:

BASIC STATE VOCATIONAL REHABILITATION SERVICES PROGRAM-SECTION 110

We are recommending an appropriation level of the full authorization amount for the Basic State Vocational Rehabilitation Program, the foundation of the programs authorized in the Rehabilitation Act, as amended, of $1,409.1 million. This proven, finely tuned direct service program has stood the test of time and has been well managed. Throughout its 67 year existence, this program has served millions of individuals with disabilities and has rehabilitated and placed well over 5.5 million people into meaningful, productive jobs. Comprehensive services are provided by and through State Rehabilitation Agencies, most often through cooperative agreements and contracts with other public, private, and nonprofit, community-based organizations and facilities.

In fiscal year 1986, with a four percent increase in funding over the previous year, 923,774 people with disabilities were served by State Rehabilitation Agencies -- a decline of one percent from the previous year. The President's proposal to reduce funding for this program would cause a significant decline in the numbers of persons being served.

The numbers cited below from a recent survey of all State Rehabilitation Agencies can assist in understanding the impact on services to persons with mental and physical disabilities of various possible funding levels for Section 110, Basic State Vocational Rehabilitation Services:

- Should the AUTHORIZATION LEVEL of $1,409.1 million be appropriated for fiscal year 1988, an additional 70,000 persons with mental and physical disabilities will be served by the State-Federal Rehabilitation Program.
- Should Congress appropriate only the ENTITLEMENT LEVEL of $1,300 million (based on a cost-of-living for all urban consumers of 1.5 percent), a maximum of only 800 more individuals with disabilities could be served.
- Should Congress appropriate the ADMINISTRATION'S REQUEST of only $1,228.1 million, 38,000 individuals with mental and physical disabilities will not receive services.

Therefore, the acceptance of the Administration's fiscal year 1988 recommendation could result in 108,000 fewer individuals with disabilities being served. The acceptance of a cost-of-living increase would result in over 69,000 fewer individuals with disabilities being served.

The Rehabilitation Act Amendments of 1986, enacted into law last Fall, place new requirements on the State-Federal Rehabilitation Program. For instance, for the first time, each State Agency is mandated to provide Rehabilitation Engineering Services, and must consider "supported employment" as an additional possible outcome of services. These are worthy goals. They, however, place additional demands on a service delivery system which is currently overburdened, and only, due to the lack of resources, able to provide services to 1 out of every 20 individuals eligible to receive such services.

In the light of the fact that 66 percent of individuals with disabilities aged 16 and over report that their disability prevents them from working, and that individuals with disabilities comprise the most underemployed segment of our society, it is vital that both State and Federal governments provide the funds necessary to assist individuals with disabilities to move from income-maintenance and dependency to employment and tax-paying, self-sufficient independence.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING-TITLE VII Part A AND Part B

NRA recommends an investment of $12.31 million for programs under Part A, and $25.32 million for programs under Part B, of the Independent Living Rehabilitation Services Program.

Under Part A of the Independent Living Program, state agencies provide, or arrange for the provision of, any service which may enhance the ability of a person with a disability to live independently and function within his/her family and community and, if appropriate, secure and maintain appropriate employment.

Currently, Under Part B of the Independent Living Program, 40,000 individuals are being served by 125 Federal Grant recipients who operate over 170 Independent Living Centers. The fiscal year 1987 funding level has allowed for the establishment of only 10 new Centers.

The President's request to level fund the Independent Living Program would, with the effects of inflation, severely interrupt planning and implementation, as well as reduce vital independent living services to persons with severe disabilities, effectively denying many the opportunity to move from dependency to independence. This would be economically ill-advised, as those who lose the opportunity for self-reliance often become more dependent on various local, state, and federal income maintenance programs.

The NRA urges that the Independent Living Program, Part A, Part B, in conjunction with Part C, the Older Blind Individuals Independent Living Services Program, be funded at the full authorization amounts for fiscal year 1988.

REHABILITATION RESEARCH

The NRA recommends an investment of $52 million in rehabilitation research as administered by the National Institute on Disability and Rehabilitation Research (NIDRR). The purpose of NIDRR is to provide for a comprehensive and coordinated approach to the administration and conduct of research, demonstration projects, and related activities concerning the rehabilitation of persons with disabilities. NIDRR supports research and training centers, rehabilitation engineering centers, individual field initiated research grants, fellowships and research demonstration projects. Existing research is being funded now at more than 100 educational institutions and in multiple areas of interest, including spinal injury, multiple sclerosis, arthritis, heart disease, mental illness, mental retardation, deafness, blindness and head trauma.

The President's budget request would enable all continuation grants to be funded. It would also permit about 35 new field initiated and innovative grants to be funded, fewer than the level of 50 established in prior years.

Increased investment in rehabilitation research will pay direct dividends in future years as we discover more effective ways of meeting the needs of persons with disabilities and incorporate technological and scientific advances in our direct rehabilitation services programs.

REHABILITATION TRAINING

The NRA recommends an investment of $33 million in rehabilitation training programs. Rehabilitation training grants, a critical element in providing services to persons with disabilities, are made to states and public or other nonprofit agencies and organizations, including institutions of higher education, to help ensure that adequately skilled personnel are available to provide rehabilitation services to persons with disabilities. Because rehabilitation plans are tailored to each person with a disability, vocational rehabilitation depends upon well-prepared "qualified" professionals to deliver a wide range of services. Rehabilitation training, through in-service training and related short-term/long-term training and continuing education, supports rehabilitation counseling, medicine, engineering, physical therapy, occupational therapy, therapeutic recreation, speech-language pathology and audiology, rehabilitation facility administration, rehabilitation facility and workshop personnel, interpreters for persons who are deaf, and personnel to serve persons who are blind.

The President's budget recommendation would fund rehabilitation training at 12.8 percent less in fiscal year 1988 than in 1987. Rehabilitation training efforts will be critically damaged by a cut in program funds and the overall effectiveness and success of the nation's rehabilitation programs will suffer.

The NRA recommends the full authorization level of $33 million for rehabilitation training to help end rehabilitation personnel shortages and to meet the added demand for trained personnel to work with the severely disabled and professionals in supported employment as called for by both the House of Representatives and the Senate in their respective Committee Reports accompanying the Rehabilitation Act Amendments of 1986.

Mr. Chairman, there also exists significant unmet training needs in rehabilitation facilities. These needs arise from the current demands placed on community providers in the areas of new technology, emerging populations, and an increasing number of severely disabled individuals who have previously been unemployed or underemployed.

To meet this need, NRA supports the development of a regional system of training resources whereby training would be available to all levels of facility personnel in all areas of the United States.

SUPPORTED EMPLOYMENT SERVICES FOR PERSONS WITH SEVERE DISABILITIES-TITLE VI Part C

The NRA recommends an investment of $26.47 million for Supported Employment Services for persons with severe disabilities. Established in 1986, the purpose of this program is to assist State Rehabilitation Agencies in establishing collaborative efforts with other public and private organizations to provide opportunities for placement for persons with severe disabilities in "supported employment." Individuals to be served through this program are those with severe disabilities who have traditionally been unable to achieve competitive employment.

The President's request to eliminate this program defies the clear intent of Congress. Without these funds, State Rehabilitation Agencies will find it much more difficult to bring about the important collaborative efforts necessary to establish a "supported employment" service delivery system.

The NRA recommends that supported employment be funded at the full amount authorized under Public Law 99-506, the Rehabilitation Act Amendments of 1986, in order to provide the necessary services to comply with Congress' request to enable individuals with severe disabilities to achieve employment in integrated community settings. These Part C grants are designed to enable all State Rehabilitation Agencies to provide training and time limited post-employment services leading to supported employment. It is critical that this effort be fully-funded, and that the administration's attempt to eliminate this endeavor be rejected.

PROJECTS WITH INDUSTRY-TITLE VI, Part B

The Projects with Industry (PWI) Program promotes opportunities for employment of disabled Americans through provision of placement resources and engaging private industry as partners in this rehabilitation process. The success of PWI is noted in the narrative of the Administration's proposed budget, as well as in the January 1986 report issued by Policy Studies Association, Inc.

Even at a modest level of funding, PWI has been a success nationwide. This achievement can be measured in terms of placements made and tax dollars saved. Over 125,000 placements have been made through the PWI Program and these individuals are now earning between $8,000 to $50,000 per year. Using a conservative estimate of 100,000 placements and an average annual wage of $10,000, this equals $1 billion added to the Nation's tax base. It would cost the government $5,000 to $10,000 to provide unemployment benefits to one disabled person for one year. By placing only 100,000 persons with disabilities, PWI has saved over $500 million, while another $200 million is generated in taxes paid, for a real savings of $700 million. It is interesting to note that according to Social Security Actuary Tables, an unemployed disabled male, aged 35, costs the government $176,000 in Social Security disability payments and an unemployed disabled female, aged 35, costs $140,000.

The NRA recommends that Projects with Industry be funded at its full authorization level of $17 million. The new dollars provided by the increase should be specifically targeted to new and existing projects, thereby allowing the most successful projects to expand their business and industry base to facilitate greater private sector involvement, as well as allowing new and innovative projects the chance to replicate the proven success of PWI. Graduates of PWI have had their earnings increase $1.263 million per week -- $65 million per year. The additional funding can only mean a similar increase in earnings, not to mention an overall savings of tax dollars.

CONCLUSION

Mr. Chairman, as I have previously stated, the Rehabilitation Act of 1973, as amended, is one of the most complete, well-written, and well-balanced pieces of legislation in the field of human services. In one Act, provisions are included for a comprehensive and individually-tailored program of rehabilitation services to eligible physically and mentally disabled persons; a training program to fully prepare rehabilitation personnel; a research program to develop new techniques in providing services; a special projects program to target services to specific populations; a comprehensive services program for independent living for persons too severely disabled to benefit from traditional vocational rehabilitation services; and other specially designed programs. The Rehabilitation Act and the programs it authorizes signifies our society's recognition of its responsibility to provide people with disabilities the opportunity to be full participants in the mainstream of life.

The NRA commends the Congress for its long history of progressive legislation and funding in behalf of rehabilitation programs. That Congress has responded positively to the rights and needs of persons with disabilities is, at least in part, because of its recognition that investments in rehabilitation programs are in fact, investments in a stronger United States of America. Much remains to be done.

We thank you and your colleagues in advance for appropriating funds for rehabilitation programs at the level we have recommended in this testimony.

STATEMENT OF PAMELA LECONTE, ASSOCIATION FOR EDUCATION OF REHABILITATION FACILITY PERSONNEL

Senator BURDICK. Pamela Leconte, Association for the Education of Rehabilitation Facility Personnel.

Ms. LECONTE. Thank you. Rather than waste all of my testimony time pronouncing the name of the association, we will leave it and call it AERFP. We represent rehabilitation facility trainers and educators across the country.

Currently, I am employed at the George Washington University in Washington, DC, and coordinate a regional master's degree program and inservice training project for vocational evaluators in rehabilitation.

The AERFP is a university-based education and training program which implements the Rehab Services Administration training program and priorities. It provides education and training for literally all levels of personnel who are employed in community-based organizations, rehab facilities as well as State VR agency counselors, vocational evaluators, and support staff.

Specifically, we work with and train vocational facility and community-based program personnel who account for 65,000 people who serve approximately 1 million disabled individuals in the country. We serve the disabled with a whole broad range spectrum of disabilities, including those with the most severe handicaps.

There are significant unmet training needs in rehabilitation programs throughout the country. To provide a specific example, for our training program we serve region 3, which is a six State region called the mid-atlantic region. We have over 600 facilities in our region which employ approximately 11,000 professionals. Those professional serve 135,000 disabled individuals, yet we have only one training facility for rehabilitation facility personnel and one rehabilitation facility administration personnel training program.

It is a well-known fact that they have high staff turnovers in rehabilitation facilities, partly due to the lack of trained personnel.

In addition to the typical needs for training, we have new technologies, emerging populations and the increasing influx of the more severely disabled individuals into the service system. The recent emphasis on supported employment has generated major revisions in service delivery, and this, too, has created an overwhelming need for retraining or training for most, if not all, personnel in rehabilitation programs.

We recommend an increase in training dollars to address these new demands. One area greatly affected by new initiatives is vocational assessment, where new methods technologies, techniques and strategies are needed to replace more traditional practices. If one estimates that in region 3 one staff member is responsible in each of the 600 facilities for vocational evaluation and/or work adjustment services, the professionals needing vocational evaluation or work adjustment training hovers around the 600 number.

Currently, we have two training programs to train vocational evaluators in region 3, and it is the first time that we have had such programs in the history of the region.

A training needs assessment was conducted by George Washington University in 1985 which supported the national trend that the majority of respondents do not have formal education in the areas most required of vocational evaluation personnel.

PREPARED STATEMENT

To summarize, we would like to recommend as AERFP members that the funding for training and education of upgrading the knowledge and skills of rehabilitationists be maintained or funded at at least these minimum levels: $1 million for rehab facility administration programs; $1.5 million for rehab facility and workshop personnel programs; and $1.5 million for vocational evaluation and work adjustment training programs.

Thank you very much.

Senator BURDICK. Thank you very much.

[The statement follows:]

STATEMENT OF PAMELA LECONTE

My name is Pamela Leconte on behalf of the Association for Education of Rehabilitation Facility Personnel. Our organization represents university-based education and training programs whose purpose it is to carry out the mission of the Rehabilitation Services Administration training program. We educate and train all levels of personnel employed in rehabilitation facilities and community-based organizations, as well as state vocational rehabilitation agency counselors and support staff. I am employed at the University of Missouri-Columbia as the Director of the Rehabilitation Facility Administration Program and have trained rehabilitation facility personnel for the past eight years.

Vocational facilities and community based programs make up the largest segment of the vocational rehabilitation service delivery program with more than 4,000 organizations, employing more than 65,000 professionals, and serving over 1,000,000 persons with disabilities each year. Facilities serve a broad range of persons with disabilities, including persons with spinal cord injury, deafness, blindness, mental retardation, chronic mental illness, traumatic brain injury, epilepsy, and learning disability.

Based upon our experience and daily contact with service providers, I would like to bring to your attention the fact that there are significant unmet training needs in rehabilitation facilities. These needs arise from the current demands placed on community providers in the areas of new technology, emerging populations, and an increasing number of severely disabled individuals who have been previously unemployed or underemployed. Personnel of rehabilitation facilities require training to meet these demands.

EMERGING POPULATIONS

While community providers have traditionally served the most severely disabled populations, new, emerging populations have brought about a need for training and re-training of rehabilitation professsionals. An illustrative example of a "new" population is the traumatic brain injured. Traumatic head injuries are the nation's third ranking cause of neurologic impairment and the primary cause of death and disability among persons under 35 years of age. Of the 500,000 persons who suffer a severe traumatic head injury each year, 100,000 die; 50,000 to 100,000 survive with severe impairments that prevent independent living, and more than 200,000 suffer continuing difficulties that interfere with daily living skills. This population continues to grow as the number of accidents increases and as new medical procedures rescue patients who would otherwise have died of their injuries. Rehabilitation facilities are increasingly being asked to provide post-trauma services to these individuals but often do not have the specialized knowledge or expertise necessary in serving this population. Education and training of the rehabilitation staff working with head-injured clientele for independent living skills and re-entry into the work force must be a national priority.

Community-based facilities are also being designated as the primary service providers for individuals who have previously been served by state institutions. Many states are in the process of decreasing the number of people in institutions and returning them to their community. This has put a great programmatic and financial strain on facilities who lack the expertise to serve this population who are mentally retarded, mentally ill, or often both. Many community-based facility personnel have traditionally served mentally retarded/developmentally disabled individuals. I receive many requests from facilities to provide training sessions in assessment, training, and placement of this "dually-diagnosed" population. Unfortunately, the demand for this training far exceeds our capacity to deliver the number of training sessions needed. In-service and continuing education are vital to equip community providers with the necessary knowledge and skills to serve this deinstitutionalized population.

NEW TECHNOLOGY

The amount of technology available to consumers in the United States has increased dramatically in the past ten years. The effect on rehabilitation professionals and the clients they serve has been no less dramatic. The impact of technology has been of great benefit to persons with disabilities but has also created a need; facility staff have to be trained in its use before they can pass on the necessary operational skills to the disabled. I can cite several examples from my personal experience in Missouri which speak to the issue of the necessity for training. An individual with cerebral palsy had an opportunity to use a computerized communication board but none of the local rehabilitation counselors was able to teach the client how to use it. Another example is the use of word processors with voice output utilized by blind individuals. The teachers of the disabled must be trained first before they are able to impart the knowledge and skills necessary to utilize technological assistive devices.

COMMUNITY-BASED EMPLOYMENT OPTIONS

Currently the entire rehabilitation community is in the midst of a shift from traditional service provision to focusing on the employment of the severely disabled in the community. This has come about in part from federal initiatives (Office of Special Education and Rehabilitative Services) but also from parents and consumers who believe in the right of all citizens to have an opportunity for a "regular" job. Rehabilitation facilities and community-based organizations have been asked to change their traditional focus of sheltered work and work activity to include employment services through transitional and supported work options. The traditional vocational facility offering solely sheltered employment and work activities is becoming an anacronism with a dramatic shift toward community-based placement. Supported work requires a re-education of service providers from traditional, in-house services to community-based employment where clients are first placed in a job and then trained by a job coach. The competencies of staff necessary to make this transition can only be attained by re-focusing and re-training from the traditional model of training a client first, then assisting in job placement. Because of this shift in philosophy and service delivery method, community providers are requesting training to develop competencies in the areas necessary for quality community placements. Trainers and educators are currently unable to meet the demand for training in supported employment. In our training program at the University of Missouri, we have twice the number of applications for training as we are able to accommodate.

NEED FOR TECHNICAL ASSISTANCE

The 1986 Amendments to the Rehabilitation Act have included technical assistance to state agencies and rehabilitation facilities under the training program. Technical assistance was available up until seven years ago and was a valuable component of the RSA training program. State agencies and facilities needing specialized expertise in program planning, development of community-based employment options, and applications of new technology would be able to access funds to have one-on-one assistance by experts in the needed areas. AERFP strongly urges that technical assistance to state rehabilitation agencies and rehabilitation facilities be funded in accordance with the 1986 Amendments ot the Rehabilitation Act. AERFP recommends funding technical assistance for no less than $500,000.

NEED FOR FULL FUNDING OF TRAINING

The financial resources to meet the training needs of rehabilitation personnel are far from adequate. Currently, less than $20 per employee is spent in preparation, maintenance, and upgrading of skills and knowledge necessary for an improved level of services within facilities and community based programs. The Association for Education of Rehabilitation Facility Personnel (AERFP) strongly urges Congress to support the $33 million which has been authorized under the 1986 Amendements to the Rehabilitation Act and recommended by the National Rehabilitation Coalition. If training and education of rehabilitation providers is not adequately funded, the greatest impact will be on citizens with severe disabilities who are attempting to achieve independence in all aspects of their lives.

NEED FOR FACILITY-BASED TRAINING FUNDING

The Association for Education of Rehabilitation Facility Personnel makes the following recommendations for funding of training targeted to the maintenance and upgrading of knowledge and skills of rehabilitation facility personnel:

- $1,000,000 for Rehabilitation Facility Administration programs. This amount would insure that each federal region have a training program for facility administrators. The Senate Committee Report accompanying The Rehabilitation Act Amendments of 1986 urged the Rehabilitation Services Administration to sufficiently fund at least one such program in each region.
- $1,500,000 for Rehabilitation Facility and Workshop Personnel programs. The AERFP supports training monies to educate and train personnel in transitional/supported employment options for the severely disabled with national coverage.
- $1,500,000 for Vocational Evaluation and Work Adjustment programs. Funding at this level would assist in alleviating manpower shortages of qualified evaluation and adjustment personnel within facilities.

STATEMENT OF SUZAN SHOWN HARJO, EXECUTIVE DIRECTOR, NATIONAL CONGRESS OF AMERICAN INDIANS

Senator BURDICK. Our next witness will be Suzan Harjo, executive director of National Congress of American Indians.

Welcome to the committee.

Ms. HARJO. Good morning. Senator Burdick, there is little that I can tell you that you do not already know about the unemployment situation in Indian country and the education needs. We have detailed in our prepared statement our positions on a variety of issues before this subcommittee, many of which you have already addressed in the context of the report from the Senate Select Committee on Indian Affairs.

I would just like to take a moment to thank you for all that you have done over your long history to advocate the Indian interest. That has been vital for us.

The unemployment situation in Indian country, as you know, has not been in single digits anytime this century, and on some Indian reservations the employment situation is in single digits.

We are greatly concerned about the fact that the administration since 1981 has cut 68 percent of employment and training programs for Indian people in present dollars and now is back trying to cut 4.3 percent from the fiscal year 1987 level. We simply cannot bear further cuts, and we hope that this committee will vigorously oppose the administration's plan.

We are also opposing, as you know, the Bureau of Indian Affairs Workfare Program initiative of the Assistant Secretary of Indian Affairs, whose resignation our organization has called for, resignation or removal. We feel that the Assistant Secretary for Indian Affairs is really driving the policy of the administration to undercut the needs and interests of Indian people and to privatize our resources and to do away with our rights. We are obligated to call this to the attention of Congress whenever we have the opportunity in the hope that this individual can be removed and some of these situations can be set right.

We very much oppose the funding cuts in Indian education in the Education Department and the highhanded treatment that we have received in that department of late.

We are pleased that the administration has requested a $55,000 increase in the tribal set-aside for the Vocational Rehabilitation Services Program, and since our needs are 150 times greater than that of the rest of the population in the incidence of disabling conditions, we feel that this is a minimum increase, and we do support it.

We want to especially note our needs in the bilingual education area. Without Indian people retaining our cultural distinctiveness, including perpetuation of our Indian languages, then we eventually will cease to exist as Indian people because it is the language that is the base of our oral tradition and the way we teach our children, the way we carry forward our families.

PREPARED STATEMENT

That will conclude my verbal testimony, and I trust that the written testimony will be included in the record.

I thank you again for all that you have done to help us over these many years.

[The statement follows:]

STATEMENT OF SUZAN SHOWN HARJO

Mr. Chairman and Members of the Committee, thank you for the opportunity, on behalf of the National Congress of American Indians (NCAI), to comment on the FY1988 budgets proposed by the Department of Labor, Health and Human Services and Education. NCAI is the largest national organization representing the interests of American Indian and Alaska Native governments and individuals. We will focus on testimony on several issues - Job Training Partnership Act, Administration for Native Americans (ANA), Administration on Aging and Education including Library Services, Pell Grants, Vocational Rehabilitation, Vocational Education and Bilingual Education.

JOB TRAINING PARTNERSHIP ACT

Indian and Native American Funding under JTPA

Funds set aside under two programs in the Job Training Partnership Act (JTPA) are the main resources available to tribal governments and other Indian and Native American organizations to meet the job training and job creation needs of our peoples. Those needs are the most serious of any population in the American labor force. The last published BIA data show unemployment across Indian country as equal to half of the available labor force, a figure seven times as severe as the U.S. workers generally. In individual Indian commmunities as many as 60%, 70% or 80% of the work force can be without jobs. This Committee knows the tragic consequences this produces among Indian people.

Funds for the Basic Job Training Program Would Be Cut

The Administration is asking for $58.8 million for Indian programs under Title IV of JTPA. This is a cut of $2.6 million, or 4.3%, below the amount Congress has appropriated for our programs in FY1987. The FY1987 amount is already below the pre-Gramm-Rudman level. The Administration's request for FY1988 is below the amount available for the program ten years ago, without any allowance for inflation. Nationally, Indian employment and training resources have been cut $68% percent in real dollars since 1981. This figure is derived using the Council of Economic Advisors implicit price deflators for the gross national product. The difference between the index figure for 1981 versus the 4th quarter 1986 is 30.6%. The comparable dollar figures for 1981 are $238.49 million versus $75.1 million in 1986 for Indian employment and training figures. Those figures show a 68% drop in constant dollars. Our job training programs cannot take any more cuts. This program serves 30,000 unemployed and economically disadvantaged Indian and Native workers each year. It is the largest resource available for developing the work skills of reservation workers and the only resource available to serve Indian and Native American workers in off-reservation areas.

Linkage with BIA Employment Assistance Might Be Cut

The proposed BIA workfare program would affect the current BIA Employment Assistance program. Many Indian and Native governments now try to link their JTPA activities with BIA Employment Assistance efforts in one comprehensive program to serve their people. The Administration's workfare proposal could destroy these linkages, painfully built up at the tribal level over the years without any help from either the Labor or Interior Departments. We ask the Committee to carefully analyze the impact of the proposed BIA workfare initiative on our JTPA programs and to deny any alteration in BIA Employment Assistance activities.

Other Issues

Although not directly tied to the budget proposals, we also ask the Committee's continued oversight on several issues of vital importance to Indian JTPA grantees. These include: consultation, Indian preference and performance standards, as touched on below.

Consultation

The JTPA law explicitly required the Labor Department to consult with Indian and Native leaders on policy issues. DOL has refused to comply with this requirement.

Indian Preference

The JTPA laws required DOL to use personnel with "particular competence" in Indian programs to administer those programs. The responsibility for handling Indian JTPA matters is spread all over Labor's Employment and Training Administration. There are few Indian staff people. Labor refuses to provide for any form of Indian preference in the staffing of offices handling Indian grants and making policy for Indian programs.

Performance Standards

The JTPA law required that performance standards set for Indian programs take into account the special circumstances of our programs. Labor's handling of this requirement has spread confusion and anxiety over potential loss of their grants among grantees and, even worse, is causing grantees to deny services to those who need it the most.

INDIAN EDUCATION PROGRAMS IN THE EDUCATION DEPARTMENT

With regard to Indian education programs in the Department of Education, the proposed budget for the Indian Education Act is $237 million, the same amount as appropriated in FY1987. The appropriation for the Impact Aid program is more troublesome, as the Administration is proposing to eliminate the "B" category of funding. The "B" category funding is for children who live on federal property or live with a parent employed on federal property. Payments for "A" children, who live on federal property and live with a parent who works on federal propery would be funded at the same level as in FY1987. While most Indian children fall into the "A" category of funding, there are a number of schools which receive "B" funding on the basis of Indian students. We support restoration of impact aid funding for the "B" students, and we stand in support of all the various interests who make up the the impact aid community. We also support a reasonable level of funding for construction under the Impact Aid program. The unmet need in construction which could be authorized under the impact aid law is $700 million. This compares with the Administration's request for only $5 million for construction in FY1988 and an appropriation of $22.5 million in FY1987.

Vocational Rehabilitation/Vocational Education

NCAI supports the Administration's request for a $55,000 increase in the tribal setaside in the vocational rehabilitation services program. Under the Vocational Rehabilitation Act reauthorized and signed into law last year, tribes will be afforded a better opportunity to develop their own vocational rehabilitation programs. The incidence of disabling conditions among American Indian and Alaska Native people is estimated to be 150% greater than the rest of the population. At the same time, Indian people are much less likely to have access to vocational rehabilitation programs.

BILINGUAL EDUCATION

The Administration is proposing a FY1988 budget of $143.1 million for bilingual education, the same amount as appropriated in FY1987. We strongly support bilingual education programs, and ask this Committee to be vigilant to see that no changes are made in the program that would negatively affect Native American languages.

LIBRARY SERVICES

The Administration has proposed no FY1988 funding for Library Services. The FY1987 level of funding was $132.5 million. Libraries in Indian country are few and far between. Even at the 21 tribally- controlled colleges, the library resources are far from adequate. One impediment to tribal colleges obtaining full accreditation is the need for development of adequate libraries. We were very pleased when the Library and Services Construction Act was signed into law in 1984 with its set-aside funding for tribal governments. That was a crucial foot in the door for development of library services in Indian country. We ask you to reject the Administration's proposal for termination of library services and construction, and to protect these programs which are of such potential importance to Indian and Native people.

PELL GRANTS

NCAI is a member in the National Pell Grant Coalition, an organization of 33 education, labor, student and civil rights organizations formed to promote funding for the Pell Grant Program, a major source of funding for the nation's neediest college students. We urge this Committee to reject the Administration's proposal to reduce the Pell Grant program by $1.1 billion and eliminate one million students from the program. We further urge this Committee to increase the ceiling on Pell Grants from $2,100 to $2,500 as provided in the Higher Education Act Amendments of 1986. Finally, we support a FY1987 supplemental for the Pell Grant program of $287 million in order to prevent a shortfall for grants to one million eligible recipients in the fall of 1987. We believe the costs for Pell Grant and other education scholarship and loan programs are a modest cost for the United States government to pay in the exercise of its trust duties regarding Indian education. The social and financial returns on an educated person are proof of the advisability of investing in education.

ADMINISTRATION FOR NATIVE AMERICANS/ADMINISTRATION ON AGING

The Administration has proposed that 17 programs in the Human Development Services Division of the Department of Health and Human Resources would be combined with an FY1988 funding level of $2.2 billion. These programs combined received funding of $2.3 billion in FY1987. We do not know how the decision would be made on how to allocate monies among the programs or how such multi-year contracts as through made through the Administration for Native Americans (ANA) would be treated. We understand that the Administration has not sent proposed legislation to the Congress to implement this block grant proposal. We would oppose any such block grant proposal.

Funding for Title VI of the Older Americans Act is totally inadequate to meet the needs of the Indian elders in this country. As you know, Title VI is the section of the Older Americans Act which provides funding to tribes. There are according to the 1980 Census, 58,000 Indian elders living on or near reservations and 109,000 Indian elders in the nation as a whole. By 1990 it is projected there will be over 100,000 Indian elders living on or near reservations and 200,000 Indian elders total.

Surveys by the National Indian Council on Aging of the Title VI grantees show that the tribes with grants are able to service about 50% of their elderly population. Further, only one quarter of tribes receive Title VI grants. In 1984, 43 new Title VI grantees were added to the program, thus reducing the existing 83 grantees by about $20,000 per grant. Appropriations did not rise comensurate with the number of grantees, and programs have had to reduce the number of meals served and in some cases, programs have closed. We request a FY1988 appropriations of $12.1 million which compares to the current funding level of $7.5 million. The figure of $12.1 million is the authorization level contained in H.R. 1069, the Older American Indian Services Improvement Act, recently introduced by Senator Bingaman. The bill is expected to be incorporated into the reauthorization of the Older Americans Act.

We strongly support the Administration for Native Americans (ANA). Funding for this program has been at a relatively stable level of $29 million for several years, and we believe that tribal needs justify an increase in funding. ANA serves constituencies and purposes not duplicated by other agencies. One example of ANA's importance is their grants to tribes to develop various types of codes, i.e., business, environmental and judicial. Tribal governments must have well developed codes which are appropriate to the specific government in order to serve their citizens and in order to create stable business environments on the reservations. The recently enacted laws reauthorizing the Clean Water Act, the Safe Drinking Water Act and Superfund all contain new tribal authorities under those laws, and hence there is an immediate need for tribes to develop environmental plans and codes. ANA is also important to non-federally recognized tribes. These tribes have very few resources and ANA grants are able to be of assistance in the detailed and time-consuming process in gaining federal recognition.

Senator BURDICK. Thank you. The last portion of your testimony has intrigued me a bit. In North Dakota we have no bilingual problems. Are there bilingual problems across the country?

Ms. HARJO. There are, indeed.

Senator BURDICK. Among the Indian people, I mean.

Ms. HARJO. Absolutely. What we see as the bilingual need is the ability to maintain the programs that keep intact our Indian languages and at the same time allow us to attempt to be fluent in English.

We, as you know, for some 500 years have attempted to accommodate new interests, including new languages, and some of our Indian leaders are, in the great oral tradition, quite fluent and able to get their points across in English, but we teach our history and we teach our values in our Indian languages. Even though we speak to them in English, they are the values that are traditional in the Indian languages.

Senator BURDICK. Thank you very much.

Vincent Scalia, President, National Council on Rehabilitation Education.

[No response.]

Senator BURDICK. Not here?

Is Robert Davila, President of Conference of Educational Administrators Serving the Deaf, Inc., here?

STATEMENT OF ROBERT R. DAVILA, PRESIDENT, THE CONFERENCE OF EDUCATIONAL ADMINISTRATORS SERVING THE DEAF

Mr. DAVILA. Mr. Chairman, thank you for the opportunity to come here before you. The Conference of Educational Administrators Serving the Deaf was founded in 1869 and is an organization of schools and programs providing educational services to deaf persons in this country. Nearly all State-operated schools among our membership are representative of our schools and programs that receive funds under Public Law 89–313.

It is the position of our organization that the provisions of Public Law 89–313 should not be changed and that its funding level for fiscal year 1988 should be $167 million.

The majority of our member schools in our organization which are State supported or State operated receive little or no funding under Public Law 94–142 due to State and Federal guidelines. As a result, Public Law 89–313 funds form a strong foundation of service to handicapped children from State-operated programs for deaf children and their families.

Some of the innovative programs for deaf children and their families which have been initiated with chapter I funds include inservice training, parent education, services for the multihandicapped and computer-assisted instruction.

Chapter I funds generally assist deaf students who have greater education and social emotional needs. An appropriate education for the student whose least restrictive environment is a State-operated program often requires more extensive and more expensive related services. Should Federal support be withdrawn, State and local school programs would be unable to make up for the lost services, and many deaf students would be denied the full range of services they need.

Mr. Chairman, our organization urges your support of an appropriation of at least $167 million for the important services provided for Public Law 89–313.

We also support the appropriations recommendations of the Consortium for Citizens with Developmental Disabilities for other programs related to the education of children with handicaps.

PREPARED STATEMENT

Mr. Chairman, we urge your continued support for programs providing educational and related services for deaf children. Thank you very much.

Senator BURDICK. Thank you very much.

[The statement follows:]

STATEMENT OF ROBERT R. DAVILA

The Conference of Educational Administrators Serving the Deaf [CEASD] was founded in 1869, and is an organization of schools and programs providing educational services to deaf persons. Nearly all State-operated schools for the deaf are members of CEASD, and our membership also includes a significant representation of local program models of various types. We are pleased to have the opportunity to address this subcommittee regarding our concerns for quality educational programming for the deaf as they relate to fiscal year 1988 appropriations for programs serving persons with disabilities.

The State-operated schools among our membership are representative of the programs most likely to be recipients of funds under chapter I of the Education Consolidation and Improvement Act of 1981, also known as Public Law 89-313. Because of our membership's knowledge of the significant impact these funds have had on educational opportunities for deaf children, the bulk of our testimony is in support of the reauthorization of Public Law 89-313 and its continued funding.

It is the position of CEASD that the provisions of Public Law 89-313 should remain intact and that its funding level for fiscal year 1988 should be $167 million.

The importance of Public Law 89-313 funds to the education of deaf children is clear. In addition to State funding, handicapped children receive funding from two essential Federal sources: Public Law 94-142 and Public Law 89-313. The majority of CEASD member schools which are State-operated or State-supported receive little or no funding from Public Law 94-142, due to State and Federal guidelines, unless the funds come from the discretionary portion of a State's allotment. As a result, Public Law 89-313 funds typically form a strong foundation to service to handicapped children from State-operated programs. Some of the innovative programs for deaf children and their families which have been initiated with chapter I funds include inservice training for State school and local education agency personnel, parent education, services for the multihandicapped, and computer assisted instruction.

Chapter I recipients generally serve deaf students with greater educational and social/emotional needs. An appropriate education for the student whose least restrictive environment is a State-operated program often requires more extensive and more expensive related services. Should Federal support be withdrawn, State and local school programs would be unable to make up for the lost services and many deaf students would be denied the full range of services they need.

The administration's efforts to revamp chapter I and withdraw its specific support would have a disastrous effect on the education of deaf children. The result would be to penalize students whose individual education program [IEP] calls for placement in a State-operated school or program by depriving them of Federal moneys which are available to handicapped children in other educational settings.

Mr. Chairman, CEASD urges your support of an appropriation of at least $167 million for the important services provided through Public Law 89-313.

The CEASD also supports the appropriations recommendations of the Consortium for Citizens with Developmental Disabilities for other programs related to the education of children with handicaps. Specifically, our membership strongly supports the following fiscal year 1988 appropriations: (1) $2,109.12 million for the State and local grants programs of Public Law 94-142; (2) $216 million for preschool grants; (3) $75 million for the early intervention program; (4) $25.87 million for early education for handicapped children; and (5) $74.5 million for special education personnel development.

Mr. Chairman, we urge your continued support for programs providing educational and related services for deaf children. Thank you.

Senator BURDICK. Our next witness will be John E. D. Ball, president of the National Captioning Institute, Inc. Is he present?

[No response.]

STATEMENT OF SHELLEY TEED-WARGO, COORDINATOR FOR CONSUMER AFFAIRS, UNITED CEREBRAL PALSY ASSOCIATION

Senator BURDICK. Then the next witness will be Shelley Teed-Wargo of the United Cerebral Palsy Associations.

Welcome to the committee.

Ms. TEED-WARGO. Good morning, Senator. I would like to submit written testimony, but I would like to also speak a few additional words on some important points.

My name is Shelley Teed-Wargo. I live in Waterbury, CT, and I am employed by the United Cerebral Palsy Assocation of northwestern Connecticut. As the coordinator of consumer affairs, I am here representing the national United Cerebral Palsy Association.

I was born with spina bifida before most of the programs I am going to talk about today were in effect. Like most people who were born with a disability, my parents were my advocates until I was old enough to advocate on my own behalf. There was no early intervention program, so my parents did what they could in my preschool years to help me stay at the same level mentally and physically as my peers, despite the many months of hospitalization that could have caused me to lag far behind other children my age.

There was no Public Law 94–142, the Education for All Handicapped Childrens Act, so my going to public school was not something that was taken for granted. Luckily I had a mother who was a fighter. She argued and fought with school administrators until they allowed me into public school. Once I was in, I still dealt with crawling up two flights of stairs to get to the school library, but I got a public education no matter how difficult it may have been.

When I finished high school, it was time for further education, a job or collecting Social Security disability and staying home to watch television. I chose to further my education. The division of vocational rehabilitation assisted me to do that. My choice was easy compared to that of many of my friends who have much more physical involvements and are in need of much more time and counselors and resources such as rehabilitation engineering and assistive technology to move out into the community to work.

Many of my friends do not have the right to choose whether they will find a job or stay home. They are simply told that their disability is too severe and there are no jobs for people like them. They want to work. The truth is counselors would have to spend too much time and money on this person, time and money they do not have.

I work closely with the Developmental Disabilities Council in Connecticut as a member of that council. Being a member of that council has been a rewarding experience for the past few years. Using the money we receive in our basic State grant, we have been able to take a leadership role in bringing people with disabilities more fully into the community, by choosing priority activities that will assist people with disabilities to move out into their community in education, in employment, in housing and recreation.

I also work closely with the office of protection advocacy in Connecticut. They have been helpful, but I have needed their assistance many times, and all they have had the time and resources to do is give advice and hope that I could follow through on my own.

There are many people with disabilities, some still in institutions, who cannot advocate on their own behalf. There is so much time and money needed before all people are protected from the abuse and neglect they are subjected to.

I work with a group of people with disabilities, their families and friends in the greater Waterbury area in Connecticut called the Consumer Action Forum. Of great importance to them is the establishment of a center for independent living in northwestern Connecticut. There is a tremendous need to assist people with disabilities to gain the skills they will need to become independent and to advocate for the necessary community supports.

People with disabilities have been able to take some giant steps forward over the years, but we still have a long way to go to become vital parts to every community in this country. The United Cerebral Palsy Association has made recommendations in the following programs: early intervention; education for all children with handicaps; State and local grants; supported employment; vocational rehabilitation; basic State grants; Job Training Partnership Act, Developmental Disabilities Act, including the protection and advocacy and university-affiliated facilities; respite care; and independent living. We urge you to support these recommendations.

Thank you.

PREPARED STATEMENT

Senator BURDICK. Thank you very much. In your opening statement, you said your mother was a fighter.

Ms. TEED-WARGO. Yes.

Senator BURDICK. I believe you are, too.

Ms. TEED-WARGO. She taught me well.

Senator BURDICK. Thank you.

[The statement follows:]

STATEMENT OF SHELLEY TEED-WARGO

My name is Shelley Teed-Wargo. I am the coordinator of consumer affairs for United Cerebral Palsy of Northwestern Connecticut. I was born with Spina Bifida and like most kids born with disabilities, my mother advocated for me until I could advocate on my own behalf. Today I am here representing United Cerebral Palsy Association.

United Cerebral Palsy Associations, Inc., is a national network of community based providers of services to persons with severe disabilities and has about 180 affiliates in 45 states. Collectively UCPA spends about $220 million a year on these vital services.

The programs I will briefly describe are very important to individuals with disabilities especially severe disabilities, and important to their families. These programs are vital to ensuring that individuals with severe disabilities have access to education, employment, cost-effective early intervention, community based services and respite care for families. Each of the programs I will describe have proven to be effective investments by the federal government in human potential and dignity.

EARLY INTERVENTION PROGRAM

As a result of a bipartisan effort last year, P.L. 99-457 added a new Part H to the Education of the Handicapped Act. Part H establishes a new state grant program for infants from birth through age two who are developmentally disabled. It significantly expands services to infants, toddlers, preschoolers, and their families who are in need of early intervention support. All states are eligible to participate on a voluntary basis. Federal assistance is to be used for the planning, development and implementation of a statewide system. The system must be providing early intervention services to all eligible infants and toddlers at the end of a four year development phase. Also, federal funds shall be a "payor of last resort," so that other sources of support will continue to be made available.

Congress gave careful consideration to the creation of Part H and the authorization of funds to implement it. The program was enacted after gathering expert evidence about the vital importance of the earliest possible intervention for infants who are developmentally delayed or are at risk of developmental delay. Early facilitative techniques are able to prevent secondary handicaps that so often accompany the primary ones. Take for example motor patterns--without early intervention, abnormal motor patterns become ingrained, asymmetry can result and muscles become contracted. Muscles become atrophied from lack of use and a child will have motor problems for the rest of his/her life. Most children with cerebral palsy are multiply handicapped and have a critical need for speech and physical therapy to meet their needs.

Research shows that early intervention is cost effective for the children involved. A 1981 Colorado study indicated that children who participated in their preschool project required

50% fewer educational services in later years. Another study identified three different types of economic benefits: For a two year pre-school program costing $6,000 --a savings of $3,353 per child resulted from a reduced need for special education; projected increase of $10,798 per child lifetime earning on the basis of higher educational level; and projected incomes of parents freed up to work were put at $688 per child; and a total of 248% return on the cost of the original investment. Another study found participation in early intervention can save $9,000 to $10,000 in educational costs of handicapped children through age 18 compared to costs of educating handicapped children with no intervention.

Despite the proven cost-effectiveness of early intervention, the President's FY 1988 Budget recommends no funding for this program. UCPA believes that funding of early intervention is long overdue and recommends $75 million for FY 1988 as a modest and reasonable means of assisting the states in developing their early childhood intervention plans. A $75 million appropriation would match the FY 1988 authorization level. It is important to note that the Department of Education has indicated that 40 states have agreed to accept the 0-2 funds. This funding level will send a clear message to the states of continued support in this important program level.

EDUCATION OF CHILDREN WITH HANDICAPS STATE AND LOCAL GRANT PROGRAMS

Public Law 94-142, the Education for All Handicapped Children Act, provides an important partnership for federal, state and local educational agencies to work together to assure handicapped children a free and appropriate public education. Prior to its enactment, children with disabilites were not served by the public school system or received an education which did not meet their needs. Now, over 4.1 million children with handicaps nationwide ages 3-21 are receiving special education through this program.

The President's Budget proposes an appropriation which is $79 million less than the current acutal level for FY 1987. UCPA recommends $2,109. million which fulfills the congressional mandate of expanding the age range and the scope of services without placing unreasonable fiscal demands on state and local government.

SUPPORTED EMPLOYMENT

Children with severe disabilites grow up and become adults. Like all adults, they want to grow up and become self-sufficient. One major initiative of the Rehabilitation Act Amendments of 1986 is new authority and funds to allow states to provide for Supported Employment services for placement of individuals with severe handicaps, Part C, of Title VI of the Rehabilitation Act.

Supported employment is defined as "competitive work in integrated work settings" for individuals who need "on-going support services in order to perform work." Once this Program is established, State Rehabilitation Agencies will be providing training and "traditionally time limited services" leading to financial independence. Individuals to be served are those with severe disabilities for whom competitive employment has not traditionally occurred, or for whom work has been interrupted or intermittent as a result of a severe disability.

Let me begin by describing a problem states are presently facing. Because FY 1987 money will not be released until the regulations are developed in September of this year, states are working to develop Supported Employment programs with no federal assistance. Late allocation of funds in the current fiscal year should not adversely influence the FY 1988 appropriation level.

Supported Employment for many individuals with cerebral palsy is the only means by which they will achieve employment in community settings. It is critical that this effort be fully funded, enabling for the first time, employment opportunities for individuals who are severely disabled and have never had the opportunity to work in competitive employment.

For FY 1988 the President has requested zero funding of the program which defies the clear intent of Congress. Without these funds, State Rehabilitation Agencies will find it very difficult to bring about the important collaborative efforts necessary to establish supported employment throughout the country and begin to meet the employment needs of severely handicapped individuals. UCPA recommends $26.47 million which is the amount authorized by P.L. 99-506.

VOCATIONAL REHABILITATION - BASIC STATE GRANTS

In addition to adequate funding for supported employment under Title VI, it is important that Congress maintain its historical strong commitment to the basic grant program for vocational rehabilitation.

Section 110 of the Rehabilitation Act, the Basic State Grants Program, has served millions of individuals with disabilities and has rehabilitated and placed over 5.5 million individuals into meaningful, productive jobs. This program has consistently been proven to be cost effective in rendering comprehensive services to persons with physical and mental disabilities.

The President's request that funding for Section 110 be reduced by 4.1 percent or $1,228. million will further result in the weakening of the purchasing power of the Vocational Rehabilitation services dollar at a time when states are being asked to expand their services to include those individuals who previously were denied services due to the severity of their disability. The President's request can only lead to a decline in the number of individuals served.

Persons with cerebral palsy often present a unique challenge to the rehabilitation counselor. However, limited time and resources of counselors continue to have a detrimental impact on persons with cerebral palsy who want to work and become more independent. Rehabilitation engineering and assistive technology provide solutions to the communication and mobility problems of persons with cerebral palsy. UCPA is keenly aware of the need to increase funds for Vocational Rehabilitation services. We continue to work with state and local rehabilitation agencies to increase their awareness of the needs and vocational potential of persons with cerebral palsy.

UCPA recommends $1,409 million for VR State Grants for FY 1988 which is the authorization level that Congress recommended in P.L. 99-506, the recently enacted Rehabilitation Amendments of 1986. These amendments require State Rehabilitation Agencies to provide Rehabilitation Engineering Services when appropriate and contain other changes which, in conjunction with scarce resources, place more pressure on the already overburdened service delivery system. Due to limited resources and increased health care costs, State Vocational Rehabilitation Agencies are only able to serve approximately one out of every twenty eligible persons with disabilities. Millions of eligible people who could be served, are not served. Without these services, costs to the federal government are greater due to keeping individuals with severe disabilities on Social Security.

JOB TRAINING PARTNERSHIP ACT

In a recent national survey of 900 corporate executives, job training was identified as the number one reason why more persons with disabilites were not hired.

The Job Training Partnership Act (JTPA) provides employment training to persons who have disabilities through both the State Grant Program (Title IIA) and through seven national projects funded by the Pilots and Demonstration Account (Title IV). The JTPA encourages the private and public sectors to work together to train and place youth and adults who have historically experienced difficulties in the labor market such as dislocated workers, high school dropouts and people with disabilities. The State Grant Program funds are administered on a state and local level through 594 Private Industry Councils (PICS) who plan, fund, and administer training programs.

In our New York City Affiliate, funds from JTPA Private Industry Councils trained and placed 45 severely disabled individuals in computer programming and accounting data entry positions last year with salaries ranging from $13-36,000. Another 53 are due to enter the workforce this year. Ninety percent of the positions are full time. The training cost of $8,000 per year per client pays for itself in the first year of employment.

The President's request would have a mixed effect upon training and placement opportunities for individuals with handicaps. On the one hand, the FY 1988 budget request of $40.7 million for Pilot and Demonstration Projects could have a positive effect. This accounts for approximately 23 programs addressing employment needs of specific segments of the population including seven projects providing services to individuals with disabilities. The request, however, of $40 million would still leave the Pilot and Demonstration Account at only 80 percent of its FY 1983 level of $50.7 million. On the other hand, the Administration is proposing to reduce the State Block Grant Program by $57 million. This reduction would further strain the abilities of the Private Industries Councils to service those individuals who are perceived as needing more comprehensive training and placement services. Currently only 8.7 percent of all participants receiving JTPA services under this Title are individuals with disabilities according to the President's Committee on Employment of the Handicapped.

UCPA recommends a FY 1988 appropriation of $40.7 million for the Pilots and Demonstration Account and $1,934 million for the Block Grant. This recommendation will enable the Department of Labor to continue its support for these programs, initiate new demonstration projects and expand the provision of technical support to local service providers.

DEVELOPMENTAL DISABILITIES ACT

For twenty years, the Developmental Disabilities program which receives a modest level of federal funding has focused important attention on the needs and rights of persons with the most severe disabilities. The Developmental Disabilities Act has enabled individuals with substantial functional limitations to become more independent, productive, and integrated into the mainstream of community life. A concern of UCP is the President's proposed elimination of the DD program. The President has proposed a "generic appropriation" of $2.2 billion for 26 programs administered by the Office of Human Development Services, including the programs authorized under the DD Act, which would permit the administration to determine specific funding levels. UCPA opposes this attempt to eliminate Congressional authority in setting funding levels for human services programs.

Basic State Grant: Though their disabilities may be different, persons with developmental disabilities will need on-going and possibly life-long services. The Developmental Disabilities State Grant Program creates State Planning Councils responsible for planning, evaluating, monitoring, coordinating and advocating for people with developmental disabilities. Funds are used to modify or adapt generic services, promote specialized services to fill gaps, and enable more cost-effective and efficient services. Priority activities focus on case management, child development, community living and employment. The Councils, which provide policy advice to the Governors in the 57 states and territories, successfully use their small allotments to generate other public and private dollars for persons with developmental disabilities. UCPA recommends $62.2 million for the DD Basic State Grant Program in FY 1988.

The DD Act is to be reauthorized by FY 1988 and UCPA, along with other organizations representing individuals with developmental disabilities, is studying various additions to the responsibilities of the Basic State Grants which may require increased funding should Congress make changes to the programs during the reauthorization process. The recommendation of $62,2 million is a 10% increase over FY 1987 an amount necessary to bring the program to a funding level commensurate with its mandated responsibilities.

Protection and Advocacy Systems: Also contained in in the DD Act is the Protection and Advocacy Systems for persons with developmental disabilities. UCPA is recommending a FY 1988 appropriations level of $25 million. This program was established by Congress in response to public outcry against the abuse and neglect of persons with severe disabilities. The P&As are one of the most important components of the DD program because they articulate the rights of persons with developmental disabilities, many of whom still reside in institutions. The system has been underfunded since its creation and persons with developmental disabilities are still without adequate advocacy services at a time when program resources are shrinking.

University Affiliated Facilities (UAF) - UAF comprise a network of 36 full service programs and 7 satellite centers. These facilities provide (1) exemplary services at the community level to persons with developmental disabilities and their families; (2) interdisciplinary training of professionals; (3) technical assistance to agencies; and (4) dissemination of applied research and promising practices in the field of developmental disabilities. UCPA is recommending $14.76 million for FY 1988. The Administration on Developmental Disabilities is spending over $1 million less on UAF-related training activities than it did at the inception of the program in 1982.

RESPITE CARE

A further concern of UCPA is the unfortunate link between child abuse and disability. There is a critical need for federal leadership in prevention efforts.

In 1985, a UCPA study by Warren and Cohen indicated that 33 of 42 preschool programs reported 303 cases of possible abuse of children with previous disabilities. This recent UCPA study reconfirms the results of other earlier research efforts. A substantial amount of abuse of young children is taking place, some of it causing disabilities and much of it occurring to children who are already developmentally disabled.

Children with disabilities are especially vulnerable to abuse and neglect and respite care can be effectively used to reduce the incidence of abuse. Studies estimated that 9.3 to 12.5 percent of new cases of cerebral palsy each year in the U.S. are caused by child abuse. Perhaps as much as 11 percent of mental retardation was the result of violence. While the potential to abuse is inherent in all human beings abusive behavior is usually exibited by individuals unable to cope with crises.

Children with handicaps are less able to defend themselves or to physically articulate an abusive incident. It is well established that respite services have proven to be a cost-effective approach to reducing abuse and in assisting parents to keep their children with disabiiltes at home. Funding respite care for families and crisis nurseries is also cost effective by reducing the incidence of institutionalization.

Title II of the Children's Justice and Assistance Act (P.L. 99-401), the Temporary Child Care for Handicapped Children and Crisis Nurseries Act of 1986, authorizes the establishment of demonstration program grants to states to provide in home and out-of-home temporary non-medical child care for children with disabilities and children with chronic and terminal illness. The Act also authorizes the establishment of grants to states to assist in providing crisis nurseries for children who are abused and neglected. As the Act was signed into law in late August, no funds were appropriated for this program in FY 1987 and the President's FY 1988 Budget does not include any funding for this program. UCPA recommends $10 million for FY 1988 which is the full authorization level.

INDEPENDENT LIVING

Comprehensive State Services for Independent Living - Part A
Centers for Independent Living - Part B

Part A of the Title VII of the Rehabilitation Act establishes a nationwide comprehensive independent living services program to assist State Rehabilitation Agencies in serving individuals whose disabilities are so severe that they do not presently have the potential for employment but may benefit from services which may inable them to live and function more independently.

Part B of Title VII, the Centers for Independent Living Program, provide services to individuals with mental and physical disabilities that are so severe that there is presently no potential for employment. Currently, over 40,000 individuals are being served by 125 Federal grant recipients who operate 170 centers.

The President's request for level funding for part A with inflation will severely interrupt planning and implementation, and reduce vital services to persons with severe disabilities. The President's Part B request will not only reduce the current level of services but would not allow the funding of Centers to reach those individuals and geographic areas currently underserved as required in the Rehabilitation Act. More importantly, these funding levels will deny many individuals the opportunity to move from dependency to independence. UCPA recommends $12.31 million for Part A, and $25.75 million for Part B.

CONCLUSION

The appropriations for the programs I have outlined for you today have historically received strong bipartisan support. Whether it be respite care, early intervention, job training or independent living, each of these programs have proven to be cost-effective investments that enable individuals with severe disabilities to become contributors and valued members of society. UCPA urges your support of our recommendations.

STATEMENT OF JUNE M. LEFFLER, NATIONAL CAPTIONING INSTITUTE

Senator BURDICK. John E. D. Ball, president, National Captioning Institute, substituted this morning by June Leffler.

Welcome to the committee.

Ms. LEFFLER. Good morning, Mr. Chairman. I am very honored to be here this morning to present testimony on behalf of closed-caption television for the National Captioning Institute, the hearing impaired of our country and my own children. I hope today I can make you feel as good about close-captioned TV as I do.

I am not a professional person for NCI. I am the mother of three boys, two of whom were born profoundly deaf. My boys are happy and intelligent. One of the things about close-captioned television is it is really keeping the smiles on their faces.

I am here to tell you how the Senate has affected our lives over the last 6 years by providing funds for captioned television. Our boys have improved language skills. Before, when they were young, to teach them language, Dave and I used to label everything in the house. We would label the lights, the door. It would be a door one day. Next day it would be the cellar door. We would change it the third day to say basement door. We would present language visually. With closed captions, life is now captioned.

When it comes to day-to-day situations, no day is long enough for a parent to interpret everything that you and I hear naturally. The kids can now read Teenage Discussions, things that mom and dad cannot always talk to them about.

My sons are now 14, 15, and 17. My oldest son wants three jobs this summer, and I think that shows you that he is confident in himself. He is secure in the world around him, and all the money put into captions will come back by contributing adults.

TV is not a luxury. It is a necessity. You could not function in Government without knowing what is happening in our country and knowing what is happening in Europe and around our world. The important thing is there is no 4-year college program that Dave and I can save for. There are no teachers who can give them the volume of information that they will receive through closed-captioned television.

Another reason I am particularly here today is that in the last 2 years I have started a program traveling around the country, raising my own money, and talking about closed-captioned television. No matter where I go in this country, I am finding out that most of the people who could be using closed caption, especially senior citizens, do not even know what it is. They think there is a little lady doing sign language in the circle of the TV. Closed captions are like an old foreign movie where you have a dialog written.

Wherever I go in the country, people ask me what is the Government doing for closed caption, and I am so proud to tell them what our Senate and our Congress has done in the past 6 years. You have been a pioneer in it. We have a lot to do. We need a lot more programs for children. They leave school in the summer and often have parents that cannot communicate with them. They are totally isolated.

The elderly person who has been functioning their whole life that cannot hear a TV program turns it off. She turns off her experience with life. We donated a unit to a lady who is 74. She had not finished a program in 12 years. The only thing she called to tell me after using it for several weeks was I stayed up till 11. I think that is important.

A lot of parents do not understand the educational value of television, the language that is presented verbally. My children have just passed, my oldest son, the New York State region's competency level on the first try. That would not have been possible without closed-caption television.

There is just a general good feeling across this country for what is being provided, but we need more public awareness that it is out there for the people who need it.

Mr. Chairman, I cannot give the children their hearing, but what I can hope to do today is continue to provide a good quality of life to them. They use hearing aids, but they could give those up because they get very little from them. They have a special phone for the deaf. It is a TTY. It is needed. It is an important thing, but they use it 20 minutes a day.

They would never part with their decoder. There is no piece of equipment in the history of mankind that has given the deaf what a decoder does. It is like giving the blind their sight. It is matchless in value. It gives vital day-to-day information. It gives entertainment, and we need that, also.

The most important thing is it gives dignity. My sons do not have to have mom there. They do not have to have their hearing brother there, and that is a tough load for my little son. They can function as individuals.

It also gives older people their sanity, because the biggest burden of a hearing impairment is your isolation.

PREPARED STATEMENT

Mr. Chairman and committee members, the best part about closed caption is that I hope today you can feel as good about it as I do, and you have the power to give the deaf the opportunity to read what they are missing. Again, it is the most important piece of equipment ever developed for this group of people.

Thank you so much for letting me testify today.

Senator Burdick. Thank you.

[The statement follows:]

STATEMENT OF JUNE M. LEFFLER

The National Captioning Institute, Inc. (NCI) appreciates this opportunity to submit testimony in support of the FY 1988 budget needs of the Captioning and Adaptation Branch of the U.S. Department of Education. NCI is a Section 501(c)(3) nonprofit organization which provides television captioning services for hearing-impaired people with public and private support, promotes the service, highlights the companies that make it possible, and strives to ensure that all who could benefit from the service are given the opportunity to do so. NCI provides the nation's hearing-impaired population with access to television through the Line 21 closed-captioned television technology. The Line 21 technology is the defacto technical standard in North America for the delivery of captions to homes and is fully compatible with the National Television System Committee (NTSC) technical standard for television signals used in North America. The service requires a hearing-impaired person to purchase a "decoder" and attach it to his or her TV set to see the captions. NCI is also responsible for the technological development, manufacture, and distribution of the decoder, a critical activity if the service is to flourish and grow.

Since NCI submitted testimony last year, there have been encouraging developments in the amount and diversity of captioned programs; the availability of the decoders; and the participation of the private sector in the provision of the service.

Additionally, NCI recently completed a two-year reading research study under a U.S. Department of Education grant. The results of that study confirmed the rapidly growing empirical evidence reflected in numerous letters received by NCI that closed captioned television is a valuable educational resource for deaf children in reading comprehension and improving vocabulary skills. A recent letter from a deaf child reads:

> **I am nine years old and I'm deaf. I am writing to you because I want to tell you how much I like my telecaptioner.**
>
> **When I was four I started using the telecaptioner. I watched "Sesame Street" and learned about numbers, how to spell, how to be nice, and how things are made. My telecaptioner helps me learn to read and understand what people are saying.**
>
> **I learned to read so well that I go to school with all the other kids who can hear without hearing aids, and I am so proud of myself.**
>
> **Sincerely,**
> **A.H.**
> **Utah**

A letter from a parent of a deaf child states:

> **Just a short note as a parent of a deaf child to tell you how important close captioned television has been to our family.**
>
> **We have had a captioning device for three years now and have definitely seen an increase in his reading ability because of it. He is one of the few kids in his class who has one and I attribute his higher reading scores to this device.**
>
> **Thank you for your continued support of captioned programming for the deaf and hearing impaired.**
>
> **Sincerely,**
> **K. K.**
> **New York**

Also, as noted by Mr. Herb Larson, Director of Support Services for Deaf Students, California State University - Northridge:

> **A little story about one of our students. In her Introduction to Literature class she was required to read Arthur Miller's play, "Death of a Salesman." She did so, and appeared to appreciate the characterization, the plot situation, the subtle ironies inherent in the play. Then a couple of months later she watched this play, closed captioned of course, and went back to her teacher and said, "Wow, I really get it now! I understand Willy better. I understand the art of playwriting. And I could feel the real emotion in the play. NOW I know the next play I read, I will understand better."**
>
> **Yes, that is what closed-captioning has done for our deaf children. That is the educational revolution that it has brought about.**

All of the above has led NCI into a variety of projects geared to providing deaf children, particularly those from low-income families, with decoders at a reduced price.

CAPTIONED PROGRAMS DEVELOPMENTS

The number of closed-captioned programs aired weekly has increased substantially since NCI's testimony last year. These increases have all resulted from increased private sector funding.

Capital Cities, Inc./ABC and **CPB/PTV** stations continue their generous tradition of supporting captioning costs. The entire **Capital Cities, Inc./ABC** prime time schedule is now captioned as are many **PBS** adult and children's programs.

Until recently, **NBC's** participation in captioning consisted largely of paying for encoding costs (the expense incurred to place captions on a program's master tape). With the start of the 1986-1987 broadcast season, **NBC** agreed to pay for one-third of the cost to create captions and related encoding charges if matching contributions were provided. Program producers and advertisers have provided matching monies to the point where now 65 percent of **NBC's** prime time programming is captioned.

Also, **CBS** cooperated with NCI in January of this year to facilitate the live captioning of the Rose Bowl Parade and the SuperBowl. These events mark the first time live programs were captioned on **CBS**.

HBO has expanded its commitment to captioning by funding the live captioning of "color comments" accompanying the Smith-Tyson boxing match, the first boxing match ever to be captioned. **Showtime**, in addition to captioning many of its programs, cooperated with NCI in the production and distribution of a public service announcement to increase public awareness of the captioning service. The **Discovery Channel** has become the first basic cable program producer to have captions accompany its programs.

In the home video area, nearly 800 titles are now available with closed captions. Companies such as **CBS/Fox Video**, **Vestron**, and **Karl-Lorimar** caption many hours of programming. Another home video-related development is the recent announcement by **Video Trend**, a home video wholesaler, that it will donate one dollar from every sale of the "Children of a Lesser God" cassette to NCI to see decoders distributed to needy individuals.

The number of television program producers that paid for the captioning of their programs increased from eight to fourteen during the past year and includes major studios such as **Embassy Communications** and **Michael Landon** Productions. **Merv Griffin Enterprises** has agreed to pay for the captioning of two of its games shows: "Jeopardy" and "Wheel of Fortune." These are the first game shows to be captioned.

More programs in syndication are appearing with captions. The schedule includes programs for children funded by **Lorimar-Telepictures** and movie classics for adults funded by **SFM Entertainment**.

Corporate advertisers support of captioning continues to increase. **K-Mart**, **Whirlpool**, and **Kraft**, for example, now pay for the captioning of "Nightline," a **Capital Cities, Inc./ABC** public affairs program.

The increase in captioned programming due to growing private sector support is most encouraging. It only happened because of the continuing Federal Government support of the service. The support of the Federal Government must continue at its current levels so as to form the essential base upon which to build private sector support.

DECODER DISTRIBUTION DEVELOPMENTS

The Federal Government subsidy of the decoder has produced a product that is more in keeping with the financial means of many deaf families and, as a result, has stimulated the purchase of the decoder. In 1986, the first year during which the subsidized decoder was available, over 50,000 units were sold. This represents a near quadrupling of decoder sales compared to the previous four years. NCI works with the private sector primarily through its Corporate Advisory Council (CAC) to reach people for whom the approximately $200.00 purchase price of the decoder is still prohibitive. Contributions are solicited by NCI and applied to reduce the cost of decoders to low income families. NCI expects its numerous initiatives in cooperation with the private and public sectors will increase the availability of decoders to those populations most in need. NCI, as part of its commitment to hearing-impaired people, will continue these initiatives with grants and contributions from the private sector. However, at the same time, NCI realizes it must develop a decoder which will have a retail price of approximately $100.00 to enable even more people to benefit from the captioning service.

RECOMMENDATIONS

Based on the significant strides that are being made by NCI with the Federal Government and the private sector toward increasing television access for our nation's hearing-impaired people, it is recommended that the federal support of this vital program be maintained in FY 1988 at FY 1987 funding levels and that the monies be allocated by the U.S. Department of Education's Captioning and Adaptation Branch as follows:

Captioned Programs	-	$5,000,000[1]
Decoder Subsidies	-	$1,500,000
Decoder Cost Reduction Development	-	$ 500,000
Public Awareness Campaign	-	$ 500,000[2]

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[1] $1,000,000 of this amount to be used for children's programs.

[2] Funds needed to inform the public, and particularly the hearing-impaired population, about the service.

NCI believes the above are critical funding areas that fit the leadership role Congress has played in the growth and development of the closed-captioned television service.

NCI wishes to express its sincere appreciation for the confidence Congress and the Department of Education have shown in giving NCI a crucial role to play in the development of so vital a service for so many hearing-impaired people previously ignored.

Thank you for this opportunity to present this testimony.

Senator BURDICK. Our next witness will be Gordon Kaufman, president, American Instructors of the Deaf. Is he present?

[No response.]

Senator BURDICK. Is there anyone here who was scheduled to testify and has not?

[No response.]

CONCLUSION OF HEARINGS

Senator BURDICK. All right. This completes the subcommittee's public witnesses hearings on the administration's fiscal year 1988 budget request. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 11:45 a.m., Friday, May 8, the hearings were concluded, and the subcommittee was recessed, to reconvene at the call of the Chair.]

Material Submitted Subsequent to the Hearings

[Clerk's Note.—The following statements, letters, et cetera were received subsequent to the hearings and will be placed in the record at this point.]

STATEMENT OF ROBERT M. TOBIAS, PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION

I am Robert M. Tobias, National President of the National Treasury Employees Union. NTEU is the exclusive representative of over 120,000 Federal employees, including workers in the Office of the Secretary, SSA's Office of Hearings and Appeals, Human Development Services, Child Support Enforcement, and the ten regional offices of HHS. I am accompanied today by Patrick Smith, NTEU Director of Legislation and Paul Suplizio, legislative consultant.

I am pleased to present NTEU's views on the Administration's FY 1988 budget request for HHS, which is a sham not worthy of serious consideration. This budget is simply window-dressing for OMB's design to reduce Federal employment and Federal spending regardless of the social cost. The huge cuts in Social Security and drug abuse are particularly reckless and irresponsible.

If the Administration's request is approved, HHS will be cut from 147,600 work-years approved by Congress in FY 1982 to 119,100 work-years in FY 1988 -- a reduction of 19 percent. This comes on top of both program and staff cutbacks in FY 1987 resulting from OMB's requirement that the Department absorb $160 million needed to fund the recent Federal pay raise and the Federal Employee Retirement System. How long can such cutbacks continue without seriously compromising efficiency and degrading services?

The most recent Semiannual Report of HHS' Office of Inspector General demonstrates the enormous potential for waste, fraud and abuse in a budget of $334 billion that serves 54 million beneficiaries. In FY 1986, total cost savings and recoveries resulting from IG audits and investigations were $5.3 billion, or 32 times the amount achieved in FY 1981. The IG disclosed that $863 million annually in AFDC payments to ineligibles could be substantially reduced, over $700 million could be saved each year through recovery of deductible amounts that Medicare beneficiaries fail to pay for hospital stays, and increased use of pre-eligibility reviews for AFDC could save $800 million annually. These examples drive home the crucial importance of sound administration. One year's saving from improved efficiency would recover more than twice the funds OMB is trying to save through staff reductions. Sound administration could save the government billions but it cannot exist without an adequate number of civil servants to do the job. The five years we have witnessed of sweeping work under the rug will continue to result in extraordinary waste and inefficiency, unless adequate staff resources are provided.

Social Security Administration

Unless this Subcommittee immediately intervenes, the reductions in SSA underway at this moment and planned for FY 1988 will reduce Social Security staff resources 20 percent below the 1982 level, with cutbacks of another 6,400 positions planned for FY 1989-1990. Without a doubt, what we can then expect is a re-emergence of the already discredited Service Delivery plan of 1985 which called for the closing of 770 local offices. The assault on Social Security is an assault on the well-being of millions of beneficiaries who depend on their local offices and who may be too ill or infirm to travel far for assistance.

For FY 1988, we strongly urge full restoration of $284 million and 4,370 work-years cut in FY 1987, plus $63.8 million and 2,454 FTE reduction proposed for FY 1988. Congress should specify in legislation a minimum staffing level of no fewer than 76,000 average positions, and provide $4.153 billion to fund SSA in the coming fiscal year.

Office of Hearings and Appeals

Because of workload growth as continuing disability reviews are resumed, and the importance of prompt, fair, and impartial determinations in line with the new standards enacted by Congress, it is important that OHA have a sufficient number of administrative law judges (ALJ's) and staff attorneys to handle a rising caseload. In the past, there have been complaints that the average time to process an appeals case was more than a year, with some cases taking up to two years. The quality of case preparation and ALJ decisions were also criticized. These conditions have stemmed from an insufficient number of ALJ's, an insufficient number of staff attorneys, and an emphasis by SSA management on "productivity" which turned the appeals process into a numbers game. Rather than improve this situation, SSA has decided to maintain existing staffing levels in OHA despite the fact that a sharply rising caseload can be predicted. Under these conditions, production pressure to clear the maximum number of cases will undoubtedly intensify. The result will be insufficient time for proper case development, and a continuing high percentage of cases remanded by the courts. Congress should act immediately to ensure that the number of ALJ's and staff attorneys is increased in line with rising workload, commencing with a 15 percent increase to accomodate the additional cases to be heard in FY 1988.

Office of Human Development Services

In FY 1986, the House directed that OHDS staffing be maintained at 1,251 positions, and the Senate mandated 1,192 positions, as the minimum requirement for this seriously understaffed agency. Despite the congressional mandate, the Administration actually provided only 1,080 positions, demonstrating once again the futility of instructions contained in report language instead of the appropriations bill itself. HHS plans further cutbacks to 1,050 positions this year and 1,025 positions in FY 1988. Instead of being cut 18 percent, OHDS needs to be strengthened significantly in the professional staff needed to carry out its mission. The cost required to provide the 1,270 average positions recommended by NTEU is $10 million -- a relatively small sum considering the high costs to society of neglecting the serious social problems OHDS deals with.

Family Support Administration

NTEU has strongly objected to the manner in which the Office of Child Support Enforcement has been consolidated into FSA, as it violates the statutory requirement that OCSE be administered as a separate organizational unit. The policy planning function and financial review of state activity have been improperly absorbed by FSA and should be restored.

OCSE's administration has been disrupted by plans for a hasty and ill-considered relocation of its office from Rockville, MD to downtown Washington in order to merge with FSA. We strongly oppose this move because of its impact on the morale of OCSE's employes and of the separate identity of OCSE -- factors which have been vital to the high levels of performance achieved by this agency.

The Office of Family Assistance is confronted with rising workloads due to demographic factors and the implementation of new programs intended to reduce AFDC program costs. In view of this growing workload, OFA staff should be increased to maintain effective program administration. NTEU's recommendations for the Family Support Administration include program administration staff to continue the WIN program ($5.8 million and 63 average positions) plus 41 additional positions costing $1.6 million to maintain FY 1986 levels in Child Support Enforcement, AFDC, and other program areas. The total increase recommended by NTEU is thus $22.7 million and 104 average positions.

Health Resources and Services Administration

For two years, Congress has refused to go along with major proposed reductions in Health Care Delivery and Assistance, Health Professions, and the Bureau of Health Resource Development. Nevertheless, the Administration has again proposed reductions for FY 1988 and major rescissions in the current fiscal year. These reductions and rescissions would virtually wipe out effective national programs to assure adequate and accessible health care for the American people. Even though most of the FY 1987 rescissions have been rejected by Congress, employment ceilings and staff reductions continue as though the cuts were in effect. As long as OMB controls the apportionment of funds, it can continue to frustrate congressional intent to maintain adequate staffing levels. We strongly urge

Congress to mandate in legislation a minimum of 2,700 positions, which is the level provided in the FY 1987 appropriation for HRSA. This includes restoration of 72 average positions for the Federal Employee Occupational Health Program.

Departmental Management

Within the Office of the Secretary, staff reductions are proposed for Planning & Evaluation (7 FTE), Management and Budget (19 FTE), Personnel Administration (9 FTE), and Field Management (30 FTE). These reductions are not justified by any workload changes cited by the Department. Particularly in Field Management, the reduction would severely impact each region's capability to respond promptly to inquiries from Congressional district offices, State and local governments, and private citizens. NTEU's alternative budget restores these cuts by providing an additional 142 positions for the Office of the Secretary, at a cost of $5.6 million.

TABLE 1. DEPARTMENT OF HEALTH AND HUMAN SERVICES BUDGET FOR FY 1988 AND NTEU RECOMMENDATION

	FY 1986 Actual		FY 1987 Appropriation		FY 1987 After Rescissions And Absorptions		FY 1988 Request		FY 1988 NTEU Proposal (Changes)		FY 1988 NTEU Recommendation	
	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years
Office of the Secretary[1]	138,238	2,266	121,819	2,194	124,019	2,194	139,940	2,124	+5,619[a]	+142	145,559	2,266
Office For Civil Rights	15,312	377	15,285	371	15,285	371	17,395	355	+848[b]	+22	18,243	377
Office of Inspector General	40,404	1,225	30,016	1,204	30,516	1,204	38,439	1,236	+1,643[c]	+44	40,082	1,280
Office of Consumer Affairs	1,903	29	1,750	22	1,750	22	1,119	15	+731[d]	+14	1,850	29
Social Security Administration[2]	3,848,443	75,494	3,840,000	74,437	3,871,562	71,799	3,805,121	69,345	+347,804[e]	+6,824	4,152,925	76,169
Family Support Administration[3]	88,446	1,134	93,142	1,135	97,002	1,093	75,796	1,030	+22,799[f]	+104	98,575	1,134
Health Care Financing Administration[4]	94,046	3,893	85,396	3,757	93,392	3,855	105,750	3,750	+5,358[g]	+143	111,108	3,893
Office of Human Development Services[5]	57,980	1,080	61,069	1,125	66,880	1,050	67,524	1,025	+44,775[h]	+245	77,912	1,270
Health Resources and Services Administration	1,311,939	2,696	1,489,212	2,700	1,188,280	2,104	1,127,853	1,780	+373,161[i]	+920	1,501,014	2,700
Centers For Disease Control	451,571	3,859	539,067	3,626	534,639	3,626	552,956	3,541	+43,967[j]	+318	596,923	3,859

1. Includes Direct Appropriation and Working Capital Fund
2. Limitation on Administrative Expenses
3. Program Administration
4. Program Management
5. Federal Administation

TABLE 1 Continued

TABLE 1. DEPARTMENT OF HEALTH AND HUMAN SERVICES BUDGET FOR FY 1988 AND NTEU RECOMMENDATION

	FY 1986 (Actual)		FY 1987 Appropriation		FY 1987 After Rescissions And Absorptions		FY 1988 (Request)		FY 1988 NTEU Proposal (Changes)		FY 1988 NTEU Recommendation	
	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years	($000) Amount	Staff-Years
Alcohol, Drug Abuse, and Mental Health Administration[6]	927,198	1,546	1,313,970	1,587	1,303,970	1,587	1,037,873	1,692	+270,658[k]	-0-	1,308,531	1,692
Assistant Secretary for Health[7]	99,749	1,006	117,066	977	112,126	977	251,047	984	+10,510[l]	+67	261,557	1,051
TOTAL RECOMMENDED ADDITIONS									+1,093,466	+8,843		

6. Excluding St. Elizabeth's Hospital

7. Public Health Service Management

NOTES

a. For the Office of the Secretary in FY 1988, 1208 average positions (FTE) are shifted to funding from the Working Capital Fund which provides centralized support servies to departmental operating divisions. The consequent reduction in the direct appropriation is a bookkeeping reduction only. NTEU's proposal restores total positions in the Office of the Secretary to the FY 1986 program level.

b. For Office of Civil Rights, an additional $848,000 and 22 average positions (FTE) is provided to maintain the FY 1986 program level.

c. Office of the Inspector General is increased 32 average positions in the Administration's request for FY 1988. However, this would only maintain OIG at the post-Gramm-Rudman-Hollings level. The FY 1986 pre-sequester level was 1,280 average positions, and NTEU's proposal would restore this level based on the need to promote efficiency and guard against waste and abuse in the expenditure of the huge sums dispensed by the Department. Moreover, each dollar spent in audit and investigations returns a multiplied amount in actual and potential savings.

d. Office of Consumer Affairs includes $731,000 and 14 average positions to maintain the FY 1986 program level.

e. For Social Security Administration, NTEU would restore $284 million and 4,370 FTE (work-years) cut in FY 1987 plus $63.8 million and 2,454 FTE proposed for reduction in FY 1988.

f. Family Support Administration includes program administration staff to continue the WIN program ($5,806 million and 63 average positions) plus 41 additional positions costing $1.573 million to maintain FY 1986 levels in child support enforcement, AFDC, and other program areas. In addition, a $15 million reduction for Interstate Child Support Enforcement Projects is restored, as is a $400,000 reduction in research and evaluation. The total increase recommended by NTEU is thus $22.779 million and 104 average positions.

g. HCFA reduction from 3,893 to 3,757 average positions enacted for FY 1987 was unwarranted in view of significant workload increases. This is evidenced by the fact that the positions actually realized in FY 1987 were 3,855. NTEU's proposal restores HCFA to the FY 1986 staffing level of 3,893 average positions. This is a reduction from 4,020 positions actually attained in FY 1985.

h. For Human Development Services, includes restoration to FY 1987 level appropriated by Congress, plus 145 additional positions for the Administration for Children, Youth, and Families, Administration on Aging, Administration for Developmental Disabilities, and Administration for Native Americans. These agencies remain seriously understaffed and have been forced to curtail essential programs.

i. HRSA includes full restoration of FY 1987 proposed rescissions and FY 1988 program reductions in order to maintain programs at levels appropriated by Congress for FY 1987. Reductions restored to FY 1987 appropriated levels include 497 average positions (FTE) for National Health Service Corps, 44 average positions for Hansen's Disease Center, 72 average positions for Federal Employee Occupational Health, and 303 average positions for Program Management.

j. Centers for Disease Control includes restoration of reductions in a variety of essential programs, such as immunization grants, sexually-transmitted disease grants, prevention centers, and occupational safety and health research, at a cost of $33.363 million. In addition, NTEU's proposal would maintain FY 1986 program levels by adding 318 average positions at a cost of $10.6 million.

k. ADAMHA includes restoration of $270.6 million in program reductions, primarily in the Substance Abuse Initiative ($222.3 million) but also in alcoholism, mental health, and other program areas.

l. The FY 1988 request for OASH shows a dollar increase because of program transfers into the office, a bookkeeping change. In fact, program reductions consisting of $10.5 million and 67 FTE were imposed in a number of important areas such as health statistics, familiy planning, and cooperative agreements related to disease prevention. NTEU's proposal fully restores these reductions.

STATEMENT OF HELLA K. FRANK, R.N., B.A., PRESIDENT, FEDERAL PROFESSIONAL NURSES ASSOCIATION, LOCAL 2707, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

I am Hella Frank, President of the Federal Professional Nurses Association, Local 2707 of the American Federation of Government Employees. I represent the nurses of the Public Health Service who staff the public health units. We provide health care to Federal employees throughout the government. I deeply appreciate this opportunity to submit testimony on behalf of the nurses and in support of the Federal employees' occupational health care program.

In the scheme of things, the dollar value of our nursing service for Federal employees is insignificant compared to the multi-billion dollar budget of the Department of Health and Human Services which you are considering. But, occupational health care is so important to the welfare of government workers. We believe that this health care -- and our jobs as well -- are in jeopardy. This is why I asked to submit this testimony.

The Public Health Service as authorized by law has provided health care directly to Federal employees since 1798. For almost two hundred years, PHS has fulfilled its primary purpose -- to furnish on the job occupational health services to government employees. Federal managers support the program. Public health nurses and doctors provide excellent care for Federal employees. The results include increased productivity, less absenteeism and a reduction in government liability for workmen's compensation. No other federal agency has the kind of medical expertise to deliver these services. There continues to be a growing demand for our care.

In FY 1985 Public Health provided employee health service for over 2,600 Federal entities at 161 sites in 38 states. In FY 1986 Public Health physicians and nurses, like me, had over 840,000 personal visits and contacts with Federal employees. In addition:

- We conducted over 2,628 health promotion programs to make Federal employees aware of risks to their health;
- We immunized almost 19,000 Federal employees;
- We conducted over a quarter million screenings for hypertension, cancer, glaucoma, diabetes and vision and hearing loss;
- We performed over 22,000 physical examinations for those Federal employees who really needed them;
- We provided special patient consultations for another quarter million employees -- 35,000 of whom we referred to their own physicians for treatment of conditions we discovered;
- We continued to provide on the spot emergency care for workers who were injured or became ill at work;
- And then we provided rehabilitation service for almost 30,000 employees so they could be treated at work rather than lose time visiting their own doctors.

All this good was accomplished by only 231 occupational health professionals in 161 health units around the country -- units like the one I staff at the Federal Communications Commission on M Street here in Washington.

We are proud of Public Health. We are proud of the quality of service we are providing to Federal employees. We know we are the only government entity that has the experience and the spirit to do the job.

At least, that was true until FY 1986. Then the Department of Health and Human Services revealed their new plans. From now on all Federal employee health programs would be operated on a reimbursable basis. They wanted to get out of the business of delivering health care to Federal employees. They told the Congress that they were going to close the Public Health units throughout the country. They told you that they were going to get rid of us -- the professional nurses and doctors who staff those units. All along they knew that this would destroy the national health network.

Yet, the Department decided on a "new direction" anyway. They decided to abandon health care for Federal employees. They decided to become consultants to Federal management instead. I guess that is when they decided they did not need us nurses any longer. They redefined the product Public Health would sell to the government. Instead of health care, the product would be consulting services. They redefined the client too. Instead of patient care, from now on, Public Health would provide a consulting service to management.

After the Department's plan became known, the Congress objected. In the House Report accompanying the 1986 appropriation bill, the Committee clearly objected to the Public Health Service plan to phase out the reimbursable health unit program. The Department was directed to restore the professional full time employee positions that staff our units. The Department was directed also to submit a more workable plan to maintain essential medical services to Federal employees and to protect the rights of the career employees who staff those units.

The Department submitted that plan in May 1986. They insisted on their "new direction" -- consulting with Federal managers rather than providing health care for government employees. They insisted that the manager not the employee was to be the primary focus of Public Health's efforts. Despite Congressional direction to keep our Public Health professional positions intact, the Department reported that it was phasing down the use of Federal professionals in Public Health units. They began a big propaganda effort to sell this new "state of the art" approach to Federal managers.

I have been told Mr. Chairman, that their sales efforts failed. I do not doubt it either. What executive director in his right mind would choose consulting services in place of health care for his employees? The failure of Public Health officials to sell this new concept is apparent in the first plan filed with the Congress. The Department suggested that "Managers must be seductively educated and co-opted to utilize" . . . this new approach. No amount of seductive education can sell this plan. It is basically flawed. It ignores the best interests of Federal employees.

The Department's plan ignored Congressional directions as well. It was not responsive to honest concerns. The plan was rejected and the Department was ordered to file again. The revised report was filed in March 1987.

The revised report is no more responsive to Congressional directions and concerns than the original plan.

- They are still committed to the abandonment of health care for Federal employees and to offering consulting services instead;
- They are still committed to replacing professional full time employees in the operation of Public Health units throughout the country; and

- They are still committed to reducing the number of full time professional medical employees.

The Department has still failed to submit a workable plan to protect the rights of the career employees who staff the Public health units. We are afraid that our jobs are being abolished without sufficient care as to our future.

The Department is doing what I think is called an "end run." Out of deference to the House Appropriations Committee, they have agreed to be responsible for the operation of the health unit program. But in total disregard of instructions, the Department is reducing the complement of professional medical employees who staff the units. The Department is hiring "temps" or contracts to replace us. By September 1988 our strength will be reduced to 174 people.

The Department is dismantling our group of specialized occupational health nurses at a time when an acute shortage of registered nurses exists nationwide. A recent editorial in the Washington Post, which I have appended to this statement, emphasizes the critical nature of this nursing shortage. In Washington, D.C. hospitals alone, almost 1,000 nurses are needed to staff vacancies. This is a shortage of almost 15 percent. The Department's plan to eliminate our jobs makes no sense at all.

The occupational health nurses who staff our Public Health units are professionals with special skills and knowledge in the field of public health. For the most part, the contract nurses hired by the Department to replace us have no expertise in public health. They are temporaries. They do not stay long at one agency. There is no continuity in patient care. They do not get to know the employees nor the specific health hazards those employees face. They are not properly supervised and evaluated. They have no institutional loyalty. And besides, they cost the government more than we do.

The Department itself estimates that contracting out health care will cost 150 percent or more than our services do.

Today contract nurses get between $16 and $19 dollars an hour. The average hourly rate paid to a full time Public Health nurse is under $15 dollars and that includes benefits. So the replacement of full time Federal medical professionals is not cost efficient. It certainly does not serve the best interests of Federal employees. The only thing it does serve is the Department's desire to get out of the business of providing health care to government workers and this, despite the clear intent of Congress to the contrary.

In closing, Mr. Chairman, I can only ask this Committee -- as one nurse representing a small group of dedicated medical professionals -- to protect the rights of Federal employees to obtain the best medical care possible on the job. I ask you also to protect the rights of Public Health nurses as career employees. Please include language in this appropriations Report directing the Department to continue to operate the Public Health units with full time professional medical personnel and to protect our rights as dedicated career people.

STATEMENT OF WILLIAM J. LUCCA, JR., EXECUTIVE DIRECTOR, COMMISSIONED OFFICERS ASSOCIATION

Mr. Chairman and Members of the Committee, the Commissioned Officers Association (COA) appreciates the opportunity to present its views and recommendations on several provisions in the Department of Health and Human Services' (HHS) FY 1988 Budget that, if approved by the Congress, will adversely impact continued use of Commissioned Corps personnel in fulfilling the nation's health mission.

We believe these provisions must be carefully examined by the Committee within the context of Secretary Bowen's recently announced proposal for REVITALIZATION OF THE COMMISSIONED CORPS. The major purpose of that proposal is: To delineate specific management activities to be undertaken to improve the effectiveness, efficiency and productivity of the Commissioned Corps. Several provisions in the HHS budget are of concern to the COA. It is our belief that they are designed to systematically erode the strength and vitality of the

Corps to the point where its effectiveness will be seriously diminished.

Secretary Bowen's proposal will help to weld an efficient and effective Commissioned Corps organization that will assist HHS in fulfilling the nation's health mission. We submit, the several provisions in the HHS Budget have been inspired and aggressively promoted by the Office of Management and Budget (OMB).

An identification of the OMB proposals in the FY 1988 BUDGET APPENDIX, together with discussions and recommendations, follows:

I-K25, Retirement pay and medical benefits for Commissioned Officers

For retirement pay and medical benefits for Commissioned Officers, OMB has eliminated the "such sums as may be required during the current fiscal year", and proposes instead for FY 1988 the sum of $89,176,000 and an additional $5,000,000, if necessary. Further, it proposes for FY 1989 the sum of $95,350,000 and an additional $5,000,000, if necessary.

In its determination to eliminate the open-ended "such sums as may be required" language, OMB proposes a two-year appropriation, with a $6,174,000 increase for the second year, and an additional $5,000,000 for each fiscal year, if necessary.

The retirement and medical benefits appropriations approved by Congress for the Public Health Service (PHS) has, for many years, been an open-ended and indefinite appropriation specifying "such sums as may be required". This method, together with reasonably accurate annual projections and careful management of the rise of the entitlement, has proved to be satisfactory.

It should be noted that the Congress, in its wisdom, rejected a similar provision in the 99th Congress.

Recommendation: That the Committee reject OMB's proposal and restore the language which would specify "such sums as may be required".

I-K43 - Sec. 202, Imposes a ceiling on Reserve and Regular Corps Officers serving in the Commissioned Corps

For the first time in its budget submission to the Congress, OMB seeks to place a ceiling on the number of Reserve Officers serving in the Commissioned Corps by requesting a limitation of 3200 for such officers.

In addition, they continue to propose a reduction in the ceiling for Regular Corps officers by requesting that it be set at 2250 from 2400 for such officers.

Mr. Chairman, we believe it is important to point out to the Committee how OMB has employed a twofold strategy of (1) blocking the submission of lists to Congress of approved nominations for appointment to the Regular Corps, and (2) delaying the submission of the permanent promotion lists to the Congress to justify their continued campaign to reduce the Regular Corps personnel ceiling.

The PHS Commissioned Corps is a uniformed service personnel system which has served the PHS and the nation's health mission since the early days of the country. The structure of this uniformed service is very similar to that of the other uniformed services; Army, Navy, Air Force, Marines, Coast Guard, and National Oceanic and Atmospheric Administration (NOAA). The PHS has an active Reserve Corps which provides non-career officers with periods of service which typically run from one to five years. These active reservists contribute substantially to the ongoing efforts of the Regular Corps - a career dedicated contingent. The Reserve Corps can be easily expanded and reduced based on the program needs of the PHS. The Reserve Corps has traditionally provided one-third to two-thirds of the combined active duty strength of the Commissioned Corps.

The total strength of the Regular Corps is set yearly by the Congress in the annual Appropriation Act through a statement in the General Provision. For several decades this figure has been routinely set at 2800 until it was arbitrarily reduced to 2500 in the FY 1983 budget submission by the OMB. In FY 1986, the OMB proposed another cut of 100 and the Congress conceeded to 50. The Regular Corps limit was then set at 2450. In FY 1987, the ceiling was further reduced to 2400. The pending proposal in the FY 1988 Budget would reduce the ceiling to 2250. Such a reduction is without justification since there is a backlog of approximately 600 applicants going back several years.

The COA wishes to emphasize to the Committee that the ceiling issue is not related to the budget deficits in anyway since all active duty officers must be covered by a real personnel ceiling under regular appropriations just like any other employee.

The same holds true regarding the delay in the submission of the permanent promotion lists. Promotion of Regular Corps officers to their permanent grade also requires Presidential nomination and Senate confirmation. This has always been relatively routine, however, at the present time the 1984 and 1985 lists have not been cleared. The 1986 promotion boards have recommended an additional 360 Regular Corps officers for promotion and they are still pending.

The COA vigorously opposes these delays for the assimilation and promotion lists. We contend that they represent an OMB tactic to force a long-term attrition to the Regular and Reserve Corps components. Moreover, the delays contribute to early retirement or resignation of officers who have made valuable contributions to the programs for which they serve. They also contribute to a deterioration of morale among talented young officers as they are faced with making career decisions early in their professional lives.

Mr. Chairman, a statutory limitation on the number of PHS Commissioned Officers who can be appointed to the Reserve Corps would diminish management's ability to attract and retain a stable cadre of top professionals to meet the continuing program needs of the PHS. The proposed ceiling of 3200 is approximately 50 below the current active duty strength of the Reserve Corps. This is contrary to the goals of the Secretary's proposal for revitalization of the Commissioned Corps. Moreover, the OMB tactic of delaying assimilation lists as justification for reducing the ceiling for the Regular Corps must be barred by the Congress.

Recommendation: That the Committee reject the OMB proposals to establish a ceiling of 3200 for the PHS Reserve Corps. Further, the Committee reject the proposal to limit the Regular Corps ceiling to 2250. We further recommend that the Regular Corps' ceiling be restored to the more realistic level of 2800.

I-K44 - Sec. 207 - Mandates that the combined pay and benefits of PHS Corps officers shall not exceed 110 percent of the Executive Level 3 annual rate of basic pay

This is a discriminatory pay provision that would inhibit managerial ability to freely assign competent officers to key posts. Further, such a provision does not exist in the military pay structure and is without justification.

I-K44 - Sec. 207 - Pay restrictions imposed on Commissioned Corps physicians and dentists assigned to administrative or managerial posts

This provision would seriously restrict PHS authority to assign newly-recruited Corps physicians and dentists to posts commensurate with their skills and abilities. Moreover, the provision would authorize the Secretary, on a discretionary basis, to extend special, revised special or continuation pay to any physician or dentist who, through promotion or reassignment within the Corps. is assigned to an administrative or managerial post.

We are deeply concerned that PHS management flexibility to assign Corps physicians and dentists, whether they be newly-recruited or long-term officers, to the wide array of posts in the PHS will be seriously jeopardized if this discriminatory pay provision is approved by the Congress for FY 1988.

If the Administration believes the continued assignment of PHS Commissioned Corps officers should somehow be modified, we are adamant in our view that they incorporate their multiple proposals into a legislative package for submission to the substantive legislative committees with jurisdiction over health matters. Full and open hearings should be held on such proposals with testimony from the many professional organizations that comprise the health community. Through this process, the Congress could then arrive at an informed judgement on the role of the PHS Commissioned Corps vis-a-vis our nation's health effort.

It should be noted that the Congress, in its wisdom, rejected a similar provision in the 99th Congress.

Recommendation: That the Committee reject the two foregoing pay restrictions proposed by OMB.

Mr. Chairman, our organization appreciates the thoughtful work of this Committee in providing adequate funding for health programs that are so important to the physical and mental well-being of our nation's citizens. We are hopeful that you will be able to accept our recommendations with respect to the several budget provisions discussed in our statement.

Statement of Michael K. Gemmell, Executive Director, Association of Schools of Public Health

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM MIKE GEMMELL, EXECUTIVE DIRECTOR OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH. THE DEANS FROM THE 24 SCHOOLS OF PUBLIC HEALTH APPRECIATE THE OPPORTUNITY TO PRESENT OUR VIEWS ON FUTURE FUNDING OF ACADEMIC PUBLIC HEALTH PROGRAMS.

APPLICATIONS OF THE PRINCIPLES AND PRACTICE OF PUBLIC HEALTH HAVE HAD DRAMATIC RESULTS IN RECENT TIMES. THE NEAR ELIMINATION OF POLIO AND THE WORLDWIDE ERADICATION OF SMALLPOX ARE JUST TWO EXAMPLES OF PUBLIC HEALTH RESEARCH AND PRACTICE AT WORK. AMERICANS BORN IN 1984 HAVE AN AVERAGE LIFE EXPECTANCY AT BIRTH OF 74.7 YEARS, A GAIN OF NEARLY THREE YEARS SINCE 1974. FOR THE FIRST TIME IN HISTORY, ADULTS ARE GAINING ABOUT TWO YEARS PER DECADE.

THIS IS, PERHAPS, ONE OF THE MOST IMPORTANT HEALTH PROMOTION AND DISEASE PREVENTION DEVELOPMENTS OF THIS CENTURY. HOWEVER, WE ARE SPENDING BILLIONS ON TREATMENT OF CHRONIC DISEASES AND BILLIONS ON RESEARCH TO FIND CURES FOR SUCH DISEASES, WHILE AT THE SAME TIME DEVOTING LITTLE OF OUR HEALTH CARE DOLLAR TO FINDING WAYS TO PREVENT DISEASES. WE ESTIMATE THAT THE TOTAL EXPENDITURES FOR PREVENTION TODAY AMOUNTS TO FOUR PERCENT OF OUR TOTAL HEALTH CARE BILL. CLEARLY, MORE FUNDS NEED TO BE DIRECTED TO PROGRAMS AND SERVICES THAT REDUCE THE OCCURENCES OF CHRONIC, DEBILITATING DISEASES, THEIR ACUTE EXACERBATIONS AND THEIR ATTENDANT COSTS FOR DIAGNOSIS, TREATMENT AND DEPENDENCY.

THE 24 SCHOOLS OF PUBLIC HEALTH HAVE BEEN EDUCATING HEALTH PROMOTION AND DISEASE PREVENTION PROFESSIONALS (PHYSICIANS, NURSES, DENTISTS, EPIDEMIOLOGISTS, ENVIRONMENTAL HEALTH SPECIALISTS, AMONG OTHERS) SINCE THE EARLY DECADES OF THIS

CENTURY. IN 1956 THE HILL-RHODES ACT WAS PASSED TO PROVIDE FEDERAL SUPPORT FOR THE THEN 11 SCHOOLS OF PUBLIC HEALTH TO TRAIN PERSONNEL NEEDED TO OPERATE THE NATION'S PUBLIC HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS. SINCE THEN, THE NUMBER OF SCHOOLS HAS MORE THAN DOUBLED AND ENROLLMENT HAS INCREASED FIVE-FOLD (OVER 9,500 ARE EXPECTED TO ENROLL THIS SEPTEMBER). YET, MR. CHAIRMAN, THERE ARE DEFINITE SHORTAGES OF PUBLIC HEALTH PROFESSIONALS TODAY. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, IN ITS FIFTH REPORT TO CONGRESS ON THE STATUS OF HEALTH PERSONNEL (1986), MAINTAINS THAT THERE ARE INSUFFICIENT PUBLIC HEALTH PROFESSIONALS PREPARED TO COPE WITH NEW AND EMERGING PUBLIC HEALTH PROBLEMS OF TODAY -- PROBLEMS SUCH AS BEHAVIOR-RELATED DISORDERS; WORK-RELATED DISEASES AND INJURIES; NEW AND RE-EMERGING COMMUNICABLE DISEASES; SPECIAL PROBLEMS OF THE AGED, CHILDREN, MIGRANTS, IMMIGRANTS AND THE DISADVANTAGED; TOXIC WASTE AND OTHER ENVIRONMENTAL HEALTH PROBLEMS; PREVENTION OF CHRONIC DISEASES SUCH AS HEART DISEASE, CANCER, STROKE, PREMATURE SENILE DEMENTIA, AMONG OTHERS.

TYPES OF PUBLIC HEALTH PROFESSIONALS WHO ARE TRAINED IN OUR GRADUATE PUBLIC HEALTH SCHOOLS AND FOR WHOM A NEED CONTINUES TO EXIST INCLUDE:

- EPIDEMIOLOGISTS KNOWLEDGEABLE ABOUT NON-INFECTIOUS DISEASES, NEW GENERATION INFECTIOUS DISEASES (SUCH AS AIDS, LEGIONNAIRES' DISEASE, TOXIC SHOCK SYNDROME) AND ENVIRONMENTAL HEALTH PROBLEMS
- ENVIRONMENTAL HEALTH PROFESSIONALS SKILLED IN TOXICOLOGY, ASSESSMENT OF RISKS RELATED TO HAZARDOUS CHEMICAL AND PHYSICAL AGENTS
- PUBLIC HEALTH NURSES, PUBLIC HEALTH PHYSICIANS, NUTRITIONISTS, BIOSTATISTICIANS AND HEALTH EDUCATORS PREPARED TO ADDRESS PROBLEMS OF CHILDREN, THE AGED AND THE DISADVANTAGED

BASED ON THE FACT THAT PUBLIC HEALTH PERSONNEL SHORTAGES EXIST, WE BELIEVE THAT CONTINUED FEDERAL SUPPORT IS JUSTIFIED.

FEDERAL SUPPORT IS ALSO JUSTIFIED ON THE GROUNDS THAT GRADUATES OF THE SCHOOLS OF PUBLIC HEALTH WORK PRIMARILY IN THE PUBLIC SECTOR IN THE AREAS OF HEALTH PROMOTION AND DISEASE PREVENTION AND, UNLIKE GRADUATES OF OTHER SCHOOLS OF THE HEALTH PROFESSIONS, DO NOT ENJOY LUCRATIVE INCOMES. GRADUATES OF THE U.S. SCHOOLS OF PUBLIC HEALTH REPRESENT THE BASIC RESOURCE POOL FROM WHICH FEDERAL, STATE AND LOCAL HEALTH AND ENVIRONMENTAL AGENCIES DRAW THEIR MANPOWER NEEDS. GRADUATES ALSO WORK AND TEACH IN UNIVERSITY SETTINGS, AND INDUSTRY RELIES HEAVILY ON THE SCHOOLS TO TRAIN THEIR EMPLOYEES INVOLVED IN INDUSTRIAL HYGIENE AND OCCUPATIONAL SAFETY AND HEALTH. SEE HIGHLIGHTS OF THE DATA ON 1986 GRADUATES SURVEYED LAST FEBRUARY. (ATTACHMENT A.)

PREVENTION CENTERS, ADMINISTERED BY CDC, IS ANOTHER PUBLIC HEALTH PROGRAM THAT REMAINS SUBSTANTIALLY UNDERFUNDED. OUT OF THE THIRTEEN ORIGINALLY PROPOSED, ONLY THREE HAVE BEEN STARTED IN THE LAST THREE YEARS.

AS YOU KNOW, THE PREVENTION CENTERS' PRIMARY MISSION IS TO FOCUS ON WAYS OF PROMOTING HEALTH, PREVENTING DISEASE AND INVESTIGATING NEW METHODS OF APPRAISING HEALTH HAZARDS AND RISK FACTORS. THE CENTERS APPLY APPROACHES UNIQUE TO PUBLIC HEALTH THAT HAVE PROVEN SUCCESSFUL IN CONTROLLING INFECTIOUS DISEASES AND SEEK TO FIND WAYS OF PREVENTING CHRONIC DISEASES. IN COOPERATION WITH THE CENTERS FOR DISEASE CONTROL AND NIH, THE CENTERS SERVE AS DEMONSTRATION SITES FOR TRANSLATING THIS NEW KNOWLEDGE INTO PRACTICE.

USING, AS APPROPRIATE, COMMUNITY OUTREACH AND ORGANIZATION TECHNIQUES, AS WELL AS OTHER METHODS OF EDUCATING AND MOTIVATING GROUPS AND COMMUNITIES, PREVENTION CENTERS PROVIDE HEALTH PROMOTION AND DISEASE PREVENTION SERVICES TO DEFINED POPULATION GROUPS IN COMMUNITIES. SINCE THE RESEARCH AND DEMONSTRATION MISSION OF THESE CENTERS IS A PUBLIC GOOD, IT IS APPROPRIATE THAT THEY BE PARTIALLY FOSTERED BY FEDERAL SUPPORT.

ATTACHED, MR. CHAIRMAN, IS A TABLE OUTLINING OUR FY88 REQUESTS TO CONGRESS FOR HRSA ACADEMIC PUBLIC HEALTH PROGRAMS AND

SELECTED CDC PROGRAMS OF PRIMARY CONCERN TO THE SCHOOLS OF PUBLIC HEALTH. (SEE ATTACHMENT B.) WE BELIEVE THAT CONTINUED AND, IN SOME INSTANCES, INCREASED FEDERAL SUPPORT OF PROGRAMS HIGHLIGHTED IN MY TESTIMONY IS JUSTIFIED ON THE GROUNDS THAT PUBLIC HEALTH TRAINING IS A SHARED FEDERAL, STATE AND ACADEMIC RESPONSIBILITY. PUBLIC HEALTH IS A GOVERNMENTAL RESPONSIBILITY. SCHOOLS OF PUBLI HEALTH TRAIN PROFESSIONALS FOR PUBLIC HEALTH SERVICE. CONGRESS HAS A DIRECT INTEREST IN ASSURING THAT AN ADEQUATE SUPPLY OF PUBLIC HEALTH PERSONNEL IS TRAINED PROPERLY TO OPERATE THIS NATION'S HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS, MANY OF WHICH ARE CONGRESSIONALLY MANDATED.

THANK YOU, MR. CHAIRMAN, FOR ALLOWING US THE OPPORTUNITY TO PRESENT OUR VIEWS. WE RESPECTFULLY URGE THAT YOUR SUBCOMMITTEE APPROVE OUR REQUESTS FOR PHS PROGRAMS OF PRIMARY CONCERN TO THE SCHOOLS OF PUBLIC HEALTH.

ATTACHMENT A

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

HIGHLIGHTS OF THE DATA ON 1986 GRADUATES

Surveyed in February 1987
(Preliminary Results)

Employment

80.5%	of the graduates are employed
12.4%	of the graduates have continued their education
7.1%	of the graduates are unemployed

Type of Employing Organization

47.4%	of employed graduates work for tax-supported organizations such as federal, state, regional or local government and higher education institutions
33.4%	of employed graduates work for voluntary health agencies
16.6%	of employed graduates work for proprietary organizations

Types of Services Which Graduates are Providing

36.0%	of graduates are providing administrative, planning or evaluation services
17.3%	of graduates are providing clinical, laboratory, and social services
16.0%	of graduates are providing education and training or research services
6.5%	of graduates are providing public health community organizational services
11.7%	of graduates are providing consultation services

Earning Levels of Employed Graduates

50%	of employed graduates earn less than $28,000 per year

Financial Assistance During Training

51.8%	of graduates depended on traineeships, scholarships, fellowships, grants, loans or employed subsidation as the primary source of funds for meeting educational expenses

Education Related Indebtedness

62%	of graduates reported some amount of education related indebtedness. The mean indebtedness for all graduates (including those reporting no debt after graduation) was $8,142.

ATTACHMENT B

FY88 APPROPRIATIONS REQUESTS OF THE U.S. SCHOOLS OF PUBLIC HEALTH

The Administration is proposing to end federal support to the 24 accredited Schools of Public Health in the United States*. These graduate schools train public health professionals deemed in short supply. According to the U.S. Public Health Service, there are critical shortages of epidemiologists, biostatisticians and environmental health specialists. There also is a need for public health nurses, nutritionists and health educators prepared to address the problems of children, the aged and the disadvantaged.

Given these shortages, the Administration proposes to end this year academic public health capitation, traineeships and preventive medicine residencies, as well as support for CDC's Prevention Centers and NIOSH's educational resource centers. It requests no funds for these programs in FY88.

Since there is a short supply of public health personnel in our nation and preventing disease is more cost effective than curing it, it is surprising and confusing for the Administration to propose ending federal support to Schools of Public Health. Given the present state of the deficit, certain reductions in federal spending are justified. However, to recommend cuts in programs that contribute to keeping individuals out of the costly medical care system does not make sense. Cost savings in the health care system can be achieved through greater emphasis (not reductions) on programs that keep people and communities healthy.

The Administration's justification for termination of public health school support is based on a series of false assumptions. Federal health professional manpower policy has focused almost exclusively on the supply of medical care physicians. The

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* University of Alabama at Birmingham, Boston University, University of California-Berkeley, UCLA, Columbia University, Harvard University, University of Hawaii, University of Illinois at Chicago, Johns Hopkins University, Loma Linda University, University of Massachusetts, University of Michigan, University of Minnesota, University of North Carolina, University of Oklahoma, University of Pittsburgh, University of Puerto Rico, San Diego State University, University of South Carolina, University of South Florida, University of Texas, Tulane University, University of Washington, Yale University.

Administration has based policy decision affecting other health professions (like public health or preventive medicine physicians) on conclusions relating to medical doctors. For example, studies have shown that there may be a substantial oversupply of physicians around 1990. Based on this finding, the President's 1988 budget assumes an oversupply of all health professionals and consequently targets its recommendations at minimizing the future supply of public health professionals. Available evidence indicates that an undersupply of public health personnel exists. (See the HHS "Fifth Report to the President and Congress on the Status of Health Personnel in the U.S.," March 1986.)

The Association of Schools of Public Health (ASPH) urges Congress to approve the following amounts for FY88:

Appropriations (Millions)

	Final FY 1984	Final FY 1985	Final FY 1986	Final FY 1987	Pres. FY1988 Requests	FY88 Author	ASPH Requests FY1988
Institutional Support (Capitation)	$5.0	$5.0	$5.0	$5.0	0	$5.0	$5.0
Traineeships	$2.5	$3.0	$3.0	$3.0	0	$3.0	$3.0
Preventive Medicine Residencies	$1.5	$1.6	$1.6	$1.6	0	$1.6	$1.6
Centers for Health Promotion and Disease Prevention (CDC)*	--	--	$1.5	$1.5	0		$5.0

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* P.L. 98-551 expires on September 30. There is a reasonable expectation that the program will be reauthorized. P.L. 98-551 authorized the establishment of thirteen prevention centers. Only three have been funded. The $5 million requested in FY88 would continue the present three and provide start-up funds for three more.

The Association's recommendations would provide a means whereby the federal government can share costs with the Schools of Public Health* for the training of public health professionals in short supply: epidemiologists, biostatisticians, environmental health workers, preventive medicine physicians, among others. The training of these professionals for federal, state and local health service is a federal responsibility to be shared with states and universities. Federal support also assures that prevention research findings are applied in the community through the CDC Prevention Centers.

These graduate Schools are located in only eighteen states and Puerto Rico, but train students from every state in the nation. With a faculty of over 2,000, graduate education is offered to a combined enrollment of approximately 9,500 students in such specialized areas as biostatistics, epidemiology, toxicology, environmental and occupational health, health administration, health care financing and cost containment (e.g., the DRG system was developed at a School of Public Health), nutrition, maternal and child health, social and behavioral sciences. Graduates work overwhelmingly in the public and voluntary sector (federal, state and local health agencies, voluntary health organizations, universities) and approximately 20 percent work in the private sector as preventive medicine physicians, industrial hygienists, toxicologists, occupational health and safety specialists, health economists, among others. Unlike graduates of the other health professions schools (medicine, dentistry), they do not enjoy lucrative incomes. The mean income of 1986 graduates was $30,568.

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* Schools of Public Health have been educating professionals in the techniques of health preservation and disease prevention and control since the early decades of the twentieth century. Some Schools of Public Health had their beginnings in university schools of medicine; others were conceived from the outset as autonomous units within their parent institutions. There are twenty-four accredited Schools of Public Health in the United States - eight at private and sixteen at public universities. (See footnote on page one.)

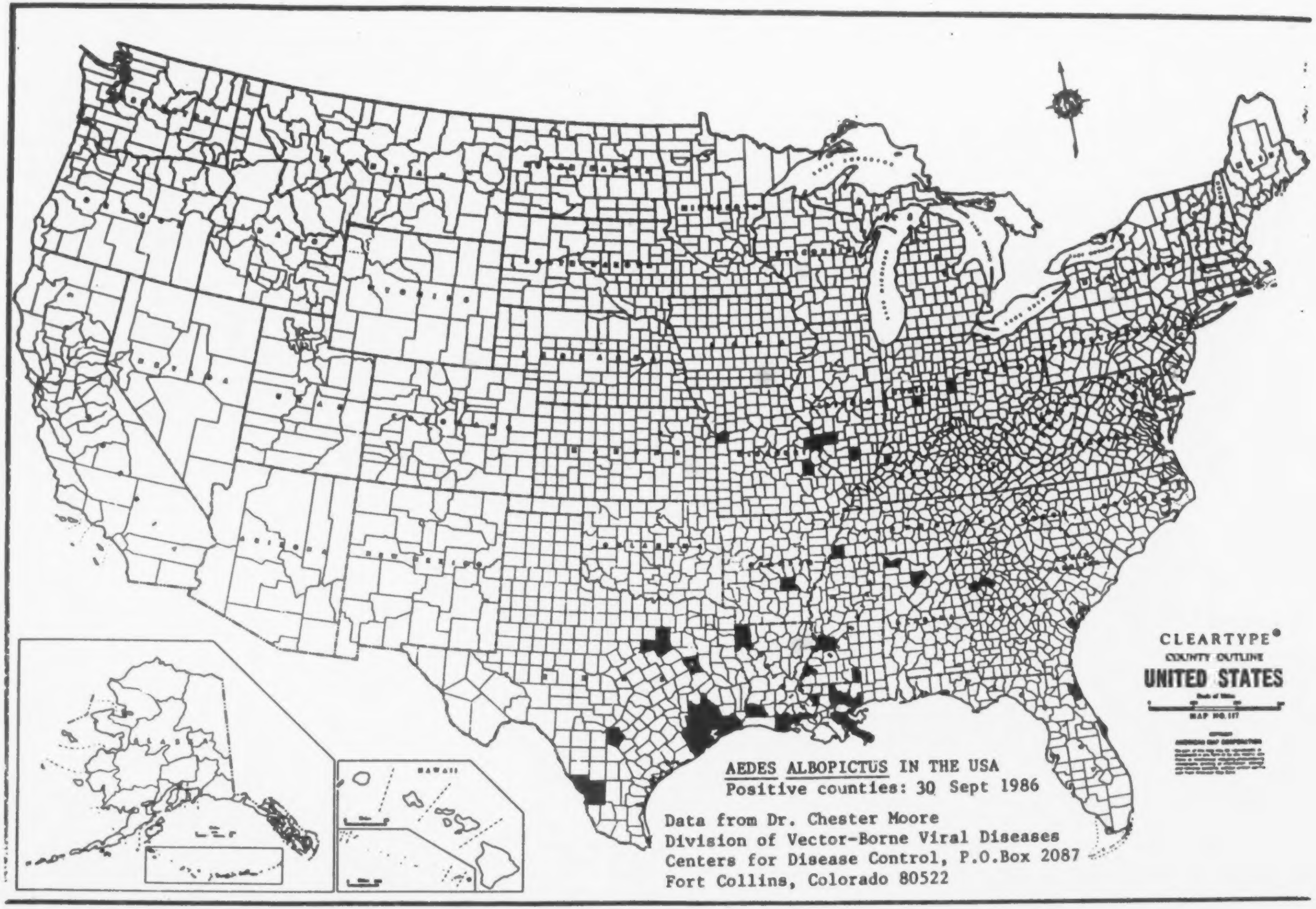
STATEMENT OF GEORGE B. CRAIG, JR., PRESIDENT, AMERICAN MOSQUITO CONTROL ASSOCIATION

Since the initial discovery of the Asian Tiger Mosquito, Aedes albopictus, in Houston, Texas in August, 1985, it has spread by the interstate transportation of tire casings, to 48 counties in 12 states. In Asia this mosquito is a major vector of Dengue and Dengue Hemorrhagic Fever, diseases which are already epidemic in Puerto Rico, Mexico, and elsewhere in the Carribean, and cases of which are imported into the U.S. annually. Recent laboratory studies have shown this species is a competent vector of California group viruses (including LaCrosse), Yellow Fever virus, epidemic poly-arthritis (Ross River) virus, and other agents. Studies on Aedes albopictus have shown that eggs of this species can successfully overwinter in northern latitudes, thus allowing its spread throughout the upper midwest where LaCrosse encephalitis is endemic.

Authorities in public health and vector control have been quick to realize the major threat the importation of this species poses. A coordinated effort between federal, state and local agencies can reduce the immediate spread of this threat, if initiated immediately and spearheaded by the Centers for Disease Control. The CDC has already been instrumental in assessing the methods of importation, spread, and potential for control. It is imperative that the CDC be supported adequately to take a leadership role in abating this major health threat. A proposed plan by which the CDC can accomplish this role is attached, along with a resolution adopted by the scientific and public health community, and a map showing the current distribution.

Recognized authorities in mosquito control and public health entomology strongly support the CDC request. This is a national problem (with strong international implications). It cannot be solved on the local level. We need port control of export and import of tires, cooperation with industry in monitoring tire shipments within the USA, development of improved methods of control of container-breeding mosquitoes, additional research on biology of Aedes albopictus. All this is provided in the CDC plan. It is work that cannot be done piecemeal by the states. If the CDC program is funded, the states should be able to take over the program which would be developed.

Please recognize the importance of funding for 1987. The matter is urgent and immediate. Experience with other introduced insects indicated that every day lost is a defeat. The longer an introduced species has to dig in and adapt, the harder becomes the task of rooting it out.


CLEARTYPE®
COUNTY OUTLINE
UNITED STATES
MAP NO. 117
HAWAII

AEDES ALBOPICTUS IN THE USA
Positive counties: 30 Sept 1986

Data from Dr. Chester Moore
Division of Vector-Borne Viral Diseases
Centers for Disease Control, P.O.Box 2087
Fort Collins, Colorado 80522

A PLAN TO DEAL WITH THE IMPORTATION, TRANSPORTATION, AND EXPORTATION OF *AEDES ALBOPICTUS*

The following elements are important for a sound national policy, by which the Centers for Disease Control, U.S. Public Health Service can assume national leadership in this matter.

A. Importation.

- A.1. Continue spot inspections of cargoes and disinsection of infested cargoes, with the encouragement of voluntary compliance of importers with anti-mosquito measures.
- A.2. Recommend new regulations regarding tire imports (e.g., dry, clean tires, sufficient airspace in cargo containers to allow efficient inspection and treatment), with spot inspections to assure compliance.
- A.3. Depending on inspections, require routine foreign fumigation or steam-cleaning of tire imports.

B. Transportation (interstate and intrastate).

- B.1. Continuing surveillance and epidemic control.
  - 1.1. Promote vector surveillance at the local and state level; maintain ovitrap surveillance in 100 cities.
  - 1.2. Improve surveillance for human diseases transmissable by *Ae. albopictus*.
  - 1.3. Provide assistance in epidemic investigations and emergency adulticiding in event of epidemics.
  - 1.4. Monitor insecticide susceptibility.
  - 1.5. Conduct research on the species biology, virus-vector relationships and control.
- B.2. Limited disease prevention programs aimed specifically at the vector.

2.1. Prevent further interstate and intrastate spread of Ae. albopictus in tires.

2.2. Initiate and maintain effective multi-state surveillance of the species.

2.3. Identify and eliminate new infestations.

2.4. Contain large, established infestations.

2.5. Conduct research on new approaches to source reduction.

C. Exportation.

C.1. Provide information and training to other countries in order to reduce the risk of importation of Ae. albopictus, including methods for surveillance and disinsection.

C.2. Seek the enforcement of existing International Health Regulations dealing with seaports and airports.

C.3. Reduce the risk of exportation of ova and larvae of Ae. albopictus in tires of containerized cargo, and small non-containerized shipments across the Mexican border; this will require a federal clarification of the regulatory agency responsible for inspection and disinsection.

The following resolution was adopted by the State Public Health Vector Control Conference at it's 16th Biennial Meeting, April 1-3. 1986. The resolution was subsequently endorsed by the following national and state scientific and public health groups:

American Mosquito Control Association
Association of State and Territorial Health Officials
Entomological Society of America
American Society of Tropical Medicine and Hygiene
Society of Vector Ecologists
Northwest Vector Control Association

and the state vector control associations of:

California
Florida
Illinois
Indiana
Kentucky
Michigan
New Jersey
Ohio
South Carolina
Utah

Aedes albopictus-infested counties reported to the Division of Vector-Borne Viral Diseases, Centers for Disease Control, by state/local agencies as of April 23, 1987.

STATE	COUNTY
Alabama	Colbert
	Cullman
Arkansas	Grant
Florida	Duval
Georgia	Chatham
	Fulton
Illinois	Jefferson
	St. Clair
Indiana	Marion
	Vanderburgh
Louisiana	Caddo
	Calcasieu
	East Baton Rouge
	Iberia
	Jefferson
	Orleans
	Plaquemines
	St. Bernard
	St. Charles
	St. Tammany
	Tangipahoa
	Vermillion
Mississippi	Forrest
	Harrison
	Hinds
	Warren
Missouri	Jackson
	St. Charles
	St. Louis
	Washington
Ohio	Darke
Tennessee	Shelby
Texas	Anderson
	Bexar
	Bowie
	Brazoria
	Chambers
	Dallas
	Ellis
	Fort Bend
	Galveston
	Harris
	Jefferson
	Liberty
	Montgomery
	San Jacinto
	Tarran
	Webb

RESOLUTION ON Aedes albopictus IN THE AMERICAS

NOW WHEREAS, Aedes albopictus, an Asian mosquito which is known to be an efficient vector of dengue fever has been introduced into the continental United States, and,

WHEREAS, this introduction poses a serious potential threat to the health of the citizens of the United States, and,

WHEREAS, the Centers for Disease Control and all state and local agencies have the responsibility to protect citizens under their jurisdiction from vector-borne diseases, and,

WHEREAS, the suppression of this infestation might be feasible if the limits of its distribution are identified and immediate control measures are taken;

NOW, THEREFORE, BE IT RESOLVED that the State Public Health Vector Control Conference urges the Centers for Disease Control to take the lead in the investigation of this infestation, establishing the exact extent of distribution of this mosquito, and using this information to design a control strategy for its suppression, and,

BE IT FURTHER RESOLVED that all appropriate state and local health related agencies in infested areas, being in the best position to take action immediately, do everything within their abilities to cooperate with the surveillance for and eventual suppression of Aedes albopictus populations in areas under their jurisdictions, and,

BE IT FURTHER RESOLVED that since Aedes albopictus is a prolific breeder in used automobile tires, that the Center for Disease Control identify routes of movement of used tires not only into the United States, but also to and from the areas of Aedes albopictus infestation, and investigate the possibility of stopping interstate movements from these areas, and,

BE IT FURTHER RESOLVED that once the extent of this infestation has been established and an appropriate control strategy has been designed, that the Centers for Disease Control seek funding from the Congress of the United States and assistance from other federal agencies to carry out control efforts in cooperation with appropriate state and local authorities.

STATEMENT OF THE ASSOCIATION FOR VITAL RECORDS AND HEALTH STATISTICS

The Association for Vital Records and Health Statistics represents health statistics programs in state and local health departments. We are affiliated with the Association of State and Territorial Health Officials, which shares the concerns presented in this statement.

We would like to highlight some issues related to the budget of the National Center for Health Statistics (NCHS).

NCHS is the primary health statistics agency in the federal government. Its responsibilities include collecting and analyzing data that are critical to maintaining and improving the health of our citizens. Some examples are the National Vital Statistics System, from which we get information about the natality and mortality experience of our population; the National Health and Nutrition Examination Survey, which provides data on nutritional and physiological health in the United States; the National Health Interview Survey, a principal source of information on the health, illness, and disability status of the population; and the National Ambulatory Medical Survey and the National Hospital Discharge Survey which provide information on the utilization of health care services.

Of these, the vital statistics produced by NCHS are the most fundamental. The National Vital Statistics System is the single most important data base for assessing the health of the United States population. It is used to monitor health problems such as infant mortality, teenaged suicide, incidence of low birth weight, heart disease, and cancer mortality. This system provides the Census Bureau with data necessary for making population estimates and projections. It is also essential to medical research and is a major source of data for the National Cancer Institute and the other institutes of health.

The National Vital Statistics System is a cooperative effort ~~betw~~een federal and state governments. Data are collected by states, processed, and provided to NCHS, in computerized form, under contract. Payment for vital statistics data is effected through a mutually agreed upon formula, which provides for the equitable distribution of funds among states. The formula is based on the philosophy that costs in the Vital Statistics Program should be shared between the states and the federal government. NCHS has stated that the federal government should fund at least 33.3 percent of costs directly related to the production of the state data tape, as determined by the formula. However, prior to FY 1987, moneys to support the program at this level were not available. FY 1987 was a potential crisis year, in which lack of funding almost caused the system to break down.

Congress exhibited strong leadership in FY 1987 by increasing the NCHS appropriation to provide funding for vital statistics at the 33.3 percent level. This action averted a breakdown and provided for the long term viability of the vital statistics system if this funding level can be maintained. Continuing to fund the program at the one-third level will allow NCHS and the states to pursue initiatives to improve our knowledge of factors related to infant mortality and to undertake other important projects that depend on the viability of the basic system.

We are pleased that the President's FY 1988 Budget includes sufficient moneys to maintain funding for vital statistics and other important NCHS programs such as the National Health and Nutrition Examination Survey. While states do not participate in conducting such surveys, as they do in the National Vital Statistics System, states rely on national data to provide benchmarks to which state health measures can be compared.

Although the Administration recognized the importance of these programs, and apparently will provide funding necessary to support them, we are concerned that some of the moneys for these projects are coming from evaluation funds rather than direct appropriations. This type of funding is less predictable. Without strong Congressional support of NCHS programs, the Administration's commitment to them may wane in future years, necessitating cuts in important programs and jeopardizing the progress made in FY 1987/88 in placing the National Vital Statistics Program on firm fiscal ground.

We urge Congress to directly appropriate the full $57 million needed by NCHS, or at the very least, to include language in the appropriations bill or accompanying report that will assure the continued availability of evaluation funds for NCHS program support.

STATEMENT OF THE AMERICAN HEART ASSOCIATION

The American Heart Association is the only voluntary agency in the United States devoting all of its human and financial resources to one goal: the reduction of premature death and disability caused by heart disease, stroke and related disorders. In accomplishing this goal we work in partnership with several research, education and prevention programs whose goals are similar in nature. One of these programs is that of the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS). We are pleased to have the opportunity to provide you with our comments and FY 1988 funding recommendations for the NINCDS.

In addition, because of our concern regarding the use of animals in research and the President's proposed elimination of the Biomedical Research Support Grant (BRSG) program, we have included comments and recommendations with regard to the NIH's Division of Research Resources (DRR) in this statement as well.

Cerebrovascular disease (stroke) is the third leading cause of death, behind heart attack and cancer, and the leading cause of long-term disability in the U.S. Approximately 500,000 individuals suffer a stroke each year; in 1984 over 155,000 individuals died of stroke. Survivors of stroke now number almost two million. These individuals often face years of severe physical and mental impairment, emotional distress and overwhelming medical expenses. It is for these reasons that stroke is generally viewed as the most devastating of all human disabilities. It is also one of the most costly as well -- each year stroke and its consequences cost the nation over $11.3 billion.

The NINCDS is the Federal focal point for all neurological research, including stroke. The Institute was established by P.L. 91-692 in 1950 and funded its first program projects and clinical research centers in stroke in 1961. Since the Institute's establishment, advances in the neurosciences have occurred at a rapid pace. Since 1950, the NINCDS has concentrated on establishing a well-trained cadre of basic and clinical sciences in the neurology field and the development of a new core of knowledge in the neurosciences. Based on these accomplishments, the Institute is now pursuing exciting new areas of research: the prevention of neurological disease, the restoration of brain function where damage has occurred and studies that will lead to an improved quality of life for those who will suffer stroke.

This new emphasis by NINCDS holds much potential for further progress in the prevention and treatment of stroke. Much of the progress against stroke in the past fifteen years has come from the identification and treatment of the major risk factors for stroke -- high blood pressure, atherosclerosis, high red blood cell count and diabetes. In the last two decades the death rate from stroke has plummeted by 52 percent.

The NINCDS Stroke and Trauma program administers basic, applied and clinical research investigations, including multidisciplinary research centers, population studies and animal studies in cerebrovascular disease. Over the past two decades, as a result of NINCDS encouragement, cerebrovascular disease has become a major focus of study at many outstanding research institutions.

The Program's 14 clinical research centers located throughout the country continue to be highly productive -- the disease process of stroke are becoming more clearly defined and significant advances have been made toward identifying predisposing high risk factors and new methods for treatment and prevention are being developed. Population studies, over a period of years, have given NINCDS-supported investigators a special time perspective from which to evaluate long-term stroke damage and treatment effectiveness. And finally, animal studies continue to make significant contributions to our understanding of stroke.

Some highlights of recent and proposed (subject to the availability of appropriations) NINCDS studies include:

- In a major international clinical trial, scientists discovered that a widely-used neurosurgical procedure to direct blood past obstructed brain arteries in stroke victims is no more effective than other available medical therapies for preventing stroke. The potential for savings from this valuable finding are great -- it is estimated that this procedure costs an average of $15,000 and several thousand are performed in the United States each year.

- NINCDS is preparing to evaluate the effectiveness of another commonly-performed surgical procedure for the prevention of stroke -- the carotid endarterectomy, in which a surgeon opens the neck artery and strips away the atherosclerotic deposits that impede circulation through the carotid artery. Many stroke experts believe that this surgery may do more harm than good because the procedure itself may cause a piece of arterial plaque to break off or trigger a clot to form, either of which would cause a stroke. Over 1,500 patients from 15 participating centers will be followed in a randomized clinical trial over a five year period. Approximately 150,000 endarterectomies are performed in the United States each year. It is anticipated that this study will provide significant and useful findings regarding the extent to which the procedure actually improves the long-term outlook for patients at risk of stroke.

- NINCDS is planning on instituting a multicenter clinical trial to determine whether prophylactic treatment with drugs reduces the risk of ischemic stroke in patients with Nonvalvular Atrial Fibrillation (NVAF), a common affliction characterized by abnormal heart beats due to factors other than damaged heart valves. Approximately 35 percent of these individuals will experience stroke during their life, and death or severe disability can be anticipated in at least half of NVAF patients who experience a stroke. The Institute is hopeful that the design of this study, a multicenter approach, will provide new information on preventive strategies for stroke in general and insights into the neurovascular basis for this particular disorder.

The President has proposed a 13.7 percent reduction in the NINCDS budget for FY 1988. The impact of this proposed level of funding on the various program mechanisms of the Institute is tremendous. In FY 1987, the Institute awarded 1,980 grants; under the President's proposed budget, only 1,907 research grants could be awarded. The Institute projects that its award rate under the President's proposed budget FY 1987 would be approximately 24 percent -- the lowest in NINCDS history. Furthermore, while the number of research centers proposed to be awarded by NINCDS under the President's FY 1987 budget would remain the same as it is in FY 1986 -- 38 -- the level of funding for the centers program would be reduced by 20 percent. Funding for research contracts would be reduced by 2 percent allowing for only 62 rather than 65 contracts to be funded. And the research training (NRSA) program would be held at its FY 1987 level of $14 million and 658 trainees.

With regard to the Institute's support for stroke research, AHA had been encouraged beginning in FY 1985 to see a stronger emphasis placed on this highly important area of need. In FY 1987, support for stroke research increased 18 percent over the FY 1986 level. Under the President's proposed budget, stroke research support would be reduced by 6.5 percent in FY 1988. At a time when research in the neurological sciences is producing such exciting findings and clearly is accelerating our ability to treat and even prevent the occurrences of such a life-threatening and costly diseases as stroke, AHA believes that it is unwise to propose decreases in funding in the very programs that will continue to have a downward impact on the incidence of stroke and its debilitating consequences. Therefore AHA would like to recommend an appropriation for the NINCDS in FY 1988 of $588.7 million. This level of funding constitutes a 20 percent increase above the FY 1987 appropriations level for NINCDS.

DIVISION OF RESEARCH RESOURCES

Laboratory Animal Sciences Program

The Laboratory Animal Sciences and Primate Research program (LASPR) housed in NIH's Division of Research Resources (DRR), is responsible for supporting research projects that enable scientists to obtain and use animals effectively in health-related research. This is accomplished through grants which provide base support for the overall resources and a

broad spectrum of multicategorical types of biomedical research conducted in seven Regional Primate Research Centers. The LASPR program also supports diagnostic laboratories, research manpower development in laboratory animal sciences, research on special nonanimal biomedical models, the improvement of laboratory animal facilities and other activities which support the various NIH programs.
In addition, The program advises NIH in the development of guidelines for the human care and use of animals in research and on the use of biomedical models which may lead to decreased use research animals.

The President's budget includes $54.9 million for the LASPR program for FY 1988. This is a decrease of .31 percent in the FY 1987 appropriation level. Two program components of the LASPR program -- primate research centers and biological models and materials development -- would receive decreases under the President's budget. The laboratory animal sciences component would receive a minimal increase.

AHA strongly believes that the LASPR program deserves a high priority for funding in FY 1988. The President's budget proposals for the DRR's animal program are highly out of line with its current needs. At a time when the public and scientific investigators continue to be concerned about providing the best possible care to research animals, it is essential that sufficient funding be provided for each of the LASPR's grant mechanisms. Therefore, AHA recommends that DRR receive a 20 percent increase over the FY 1987 appropriations level, or $387.5 million, in FY 1988.

Animal facilities and properly trained animal medicine personnel are a necessary aspect of all biomedical research activities. Furthermore, proper facilities and healthy animals help to ensure reliable research results. Our recommended 20 percent increase in DRR funding will only begin to meet the need for improving the wide-spread deterioration that currently exists in a majority of the research animal facilities located at biomedical research institutions in the U.S.

Biomedical Research Support Grant (BRSG) Program

The BRSG program was authorized in 1960 and it provides institutions heavily engaged in health-related research with a pool of flexible funds to meet particular needs determined by individual institutions not normally met by other PHS project grants. Allocating research funds on site allow research institutions to balance intervals needs to make the most effective use of emerging research concepts, techniques and talent.

The President's FY 1987 budget includes no funds for the BRSG program. We urge the Subcommittee to reject the President's proposal to eliminate this program. Our recommended funding level for the DRR for FY 1988, $387.5 million, would allow for continuation of this most important program.

Letter From Margaret Cauffield, Executive Director, Osteogenesis Imperfecta—National Capital Area, Inc.

May 11, 1987

Senate Subcommittee on Appropriations -
Labor, Health and Human Services, Education and
Related Agencies
SD-131, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Sirs:

This is an addendum to the attached letter from Terry and Theresa G. Schwantes, in support of their request for increased funding for research on osteogenesis imperfecta (OI).

In addition to increased funding for research, our organization also requests support for a training program for professional persons--doctors, nurses and therapists--and parents of affected children, based on the rehabilitation approach described in the enclosed article titled "Osteogenesis Imperfecta: Rehabilitation Approach with Infants and Young Children," by Helga Binder, M.D., et al, September 1984 Archives of Physical Medicine and Rehabilitation.

We are in constant receipt of letters and telephone calls from parents begging for help in the care of their OI-affected infants and children. It is wrenching to hear that most doctors and other professional persons are not knowledgeable about how to help parents suddenly faced with the care of an infant with brittle bones and all the other complications of OI. One doctor said to such a parent, "You teach me."

This rehabilitation research program is ongoing at the National Institutes of Health. It must be made known and taught at other hospitals and rehabilitation centers. Our goal is to see that every child with OI receives rehabilitation services. Had such treatment been in existence when my case was first diagnosed, I would very likely not be in a wheelchair, unable to walk or stand.

Thank you for reading this, and for whatever consideration you may be able to give to our requests. I may be reached at 202/732-1395 (work).

Sincerely,

Meg Cauffield

Margaret (Meg) Cauffield
Executive Director

LETTER FROM TERRY JAMES AND THERESA GILGENBACH SCHWANTES

1725 Lakeview Avenue
South Milwaukee, WI 53172
(414) 764-7421
April 26, 1987

Senate Subcommittee on Appropriations -
Labor, Health and Human Services, Education
and Related Agencies
SD-131, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Sirs:

Please allow me to submit this written testimony to the Senate Subcommittee on Appropriations for Labor, Health and Human Services, Education and Related Services.

Since April 9, 1980 our family has had a vested interest in the research on Osteogenesis Imperfecta (O.I.) being conducted at the National Institutes of Health. On that date, my daughter Brianne was born with 13 fractures that had occurred and healed while she was still in the womb. A fractured tibia that occurred at birth and small wormian bones instead of a skull. Maybe the most distressing of all, was a medical community that had invested very little in time or money to find a treatment, let alone a "cure". The hope the medical community had to offer us in 1980 and still offer many new-born O.I. parents today, is to **NOT TO PICK UP YOUR O.I. CHILD**. The medical community advises leaving those children lay and after they reach 4 years, they start to rod the major bones of the body and attempt to recover enough physical abilities to get them sitting in a wheelchair for the remainder of their lives.

In the few short years since that bleak picture was drawn for us, a group of families in conjunction with the NIH has invested large amounts of their personal time and created a physical rehabilitation program and a bracing protocol that is amassing data that will significantly affect children born today with Osteogenesis Imperfecta. My daughter Brianne, is able to attend first grade, in a "normal" classroom setting, with her long-leg polypropylene braces. The fact that she is able to walk is highly encouraging for children afflicted with O.I.. The fact that she can interact with her peers on the same level and not separated by a wheelchair has given her the skills that the majority of handicapped children never achieve. Due to the accomplishments and successes of Brianne and the others in the study, children today have rehabilitative alternatives which were not possible 7 years ago.

Our family and the other families like ours who have children with O.I., would like to encourage you to increase and not just maintain spending for the excellent research being conducted by the National Institutes of Health. The dollars spent today will help advance and build upon the enormous strides in medical knowledge that have been achieved to date.

STATEMENT OF C. THOMAS CASKEY, M.D., DIRECTOR, INSTITUTE OF MOLECULAR GENETICS, BAYLOR COLLEGE OF MEDICINE

Thank you for allowing me to present testimony relating to the need for adequately funding the National Institute of Neurological and Communicative Disorders and Stroke so that more intense research into neuropathic disorders can be encouraged.

Specifically, I would like to emphasize in my testimony the opportunity for meaningful progress in one of the more common neuropathies, Charcot-Marie-Tooth Syndrome, commonly referred to as "CMT."

It is clear that significant progress has been made on the genetic mapping of Huntington's Chorea, Duchenne Muscular Dystrophy, Myotonic Dystrophy, Alzheimer's and Cystic Fibrosis. In the case of Duchenne Muscular Dystrophy, Chronic Granulomatous Disease, and Cystic Fibrosis, the disease gene has been identified and cloned using initial gene mapping data. We anticipate that within a three to five-year period, given adequate resources, the Charcot-Marie-Tooth gene(s) can be isolated.

Charcot-Marie-Tooth disease is a genetically inherited degenerative nerve disease that was first described in 1886. The symptoms are those of a progressive muscle-wasting seen most prominently in the extremities. Presently, families and patients have no available therapy or diagnostic means of preventing the recurrence of disease because the gene(s) defect is/are unknown.

The incidence of CMT is estimated to range from one to 36 per 100,000 population for the various genetic forms. The disease serves as an example of a genetic neuropathy of intermediate incidence and significant disability.

Because CMT is the most common heritable neuropathy and since the individuals with the disease have near-normal life span despite severe disability, it presents an opportunity for favorable study. Affected family members are frequently available over several generations. This is not true for neuropathies such as Werdnig-Hoffman and amyotropic lateral sclerosis (Lou Gehrig's disease), when the affected individuals have shortened survival and thus extended families are rarely found.

Charcot-Marie-Tooth can serve as the most common disease that permits development of new technology applicable to the more difficult and rare diseases.

It is clear that CMT is at least three diseases, all inherited. Again, it offers the opportunity to find the causes of similar diseases. This is not uncommon to neurology, where frequently a diagnosis such as Alzheimer's may have several causes. But CMT offers an opportunity to genetically dissect the clinical origins.

Given adequate resources for research, I am confident the goal of isolating the CMT gene(s) can be achieved in a relatively short time span. Commitment to this research would not only benefit knowledge of CMT, but would undoubtedly lead to the development of techniques useful in the isolation of the genes associated with Friedreich's Ataxia, Werdnig-Hoffmann, Jakob-Creutzfeldt disease, heritable amyotrophic lateral sclerosis, and other neuropathies. Isolating these genes would provide physicians with the means to accurately diagnose and prevent these diseases, and possibly a means of treating those already afflicted.

Recent successes in determining the genetic location (gene map position) of some of the neuropathies, has been the result of support and scientific effort by the NIH as well as private foundations such as the Muscular Dystrophy Association and the Huntington's Chorea Disease

Foundation. These research successes are also a tribute to the U.S. leadership in biotechnology and, especially, to the support of our nation's citizens for better public health services.

We now believe that a relatively modest investment of resources in CMT research can extend our successful efforts in genetic medicine. The resources needed to execute the research are interdisciplinary, requiring neurologists for accurate diagnosis, medical and population geneticists for linkage study and analysis, and molecular biologists for gene isolation.

We therefore recommend that the Charcot-Marie-Tooth gene isolation effort is best undertaken within a research center with comprehensive skills, personnel, and dedication to the goals.

In summary, the isolation of the CMT gene(s) is achievable and will lead to methods of accurate disease diagnosis, carrier detection, prevention, and understanding of the disease defect. This will provide vital interaction needed to develop methods of treatment for those afflicted with the disease.

Finally, this research will facilitate the subsequent isolation of disease genes affecting motor and peripheral nerves, which prove fatal to the individuals afflicted with so many of the neuropathies such as Werdnig-Hoffman and amyotrophic lateral sclerosis.

It is our sincere hope, Mr. Chairman, that the Subcommittee will see fit to provide adequate financial resources to the NINCDS to achieve this realistic objective in neuropathic research.

Thank you and I will be glad to answer any questions.

STATEMENT OF THE HEALTH POLICY AGENDA FOR THE AMERICAN PEOPLE

The Health Policy Agenda for the American People (HPA), respectfully calls the Subcommittee's attention to its recommendation that federal funding for biomedical research be increased substantially. Few programs of government spending are as cost effective as basic and applied biomedical research.

Composed of representatives from 172 organizations, the HPA constitutes what we believe to be the most diverse cross-section of major stakeholders in health care ever assembled. The groups participating in HPA include the health professions, insurers, hospitals, consumer organizations, business groups, and state and federal government agencies.

During the past five years, the HPA has spent thousands of hours seeking consensus among its various groups on health care issues. Of our 195 recommendations, increased funding for biomedical research is one of our most immediate and highest priorities. We join with the on-going efforts of the Ad Hoc Group for Medical Research Funding to raise attention to this need. We submit this statement for the public record to explain why the HPA members reached consensus on this issue and why we believe that funding for biomedical research should be an exception to budget cutbacks.

The Value of Biomedical Research

While accurate figures are difficult to obtain, there is sufficient information to indicate that research is both cost-effective and important to the national economy. Over the past 75 years, we estimated that biomedical research has saved the nation from $200 to $400 billion as a result of reductions in sickness and postponement of premature death.[1] It has been estimated that the commercialization of biomedical research discoveries contributes considerably to the gross national product. For example, if the potential applications of recombinant DNA technology are achieved, about $40 billion worth of products may be produced by the year 2000.[2] Further, the preeminence of the country's biomedical research effort has important implications for national defense and competitiveness, as it represents a vast intellectual resource.

Despite its obvious cost effectiveness, funding for biomedical reseach grants has fluctuated from year to year, and over the past five years, there has been a lack of growth in federal funding. This lack of stability in funding may influence a research scientist -- often someone who has spent over ten years in training -- to pursue a career elsewhere. The lack of growth has exacerbated already existing problems in the career opportunities for young investigators, in the maintenance of a stable research environment for established investigators, and in the renewal of facilities. Substantial increases in federal funding are necessary to attract and maintain the talented scientists to meet the nation's present and future health care needs.

Society seems to recognize, implicitly and explicitly, the value of medical science. Biomedical research contributes to good health, economic well-being and the scientific preeminence of the nation.

The value of past national commitments to biomedical research is clearly apparent today as resources which have been dedicated over the past 40 years are mobilized to deal with the AIDS crisis. Faced with a new disease which cripples the body's ability to defend itself against viruses, bacteria, and cancer, those elements of the research community trained in the fields of immunology and virology first directed their efforts at uncovering the cause of this disorder. Because of past efforts, in a relatively short period of time a new virus, human immunodeficiency virus, was discovered as the causative agent. Further research led to the development of a sensitive and specific assay for the virus, which has allowed the screening of donated blood and plasma. With the number of diagnosed cases of AIDS estimated at a quarter of a million by 1991 and with an accompanying annual health care cost of between $8 and $16 billion, biomedical research is a vital resource in the development and testing of a vaccine to prevent the further spread of the virus and in the development of effective treatments for those with the disorder.

Even in light of tight federal budgets, 70% of the American people believe that the government should increase its funding for basic research by a sizeable amount.[3] A major concern for the remainder of this decade and the next is the commitment of the federal government to the availability, training, and support of biomedical researchers. At the same time, of course, private industry, philanthropic organizations, voluntary health agencies and private foundations should supplement federal government funding for biomedical research.

Availability of Funding for Research

Financial support for biomedical research comes from a variety of sources. In 1985, the government, industry, and private organizations together committed almost $13 billion to this effort. The government -- federal, state, and local -- provided about 58% of this money, industry provided about 39% and private nonprofit foundations, voluntary health organizations and others provided the remaining 3%. This seems to be -- and is -- a great deal of money. To put this figure in perspective, however, it should be noted that research and development costs for health alone represent only 12% of the nation's total support for all types of research and development costs in all fields of science and technology.[4]

In general, the absolute amount of money provided by the federal government for health-related research and development has increased over the years, but the proportion of funds as compared to total health expenditures per year has decreased.

The proportionate decrease in federal funding for research and development has been balanced to some extent by increased funding from industry, particularly pharmaceutical companies. At first glance this increased industrial investment seems to bode well for biomedical research; but private industry funds only 10% of basic biomedical research, while the federal government funds about 90%. Thus, basic research (as opposed to applied research) is more vulnerable to decreased federal expenditures.

The level of funding for biomedical research is affected by many factors, including competing national priorities, available scientific opportunities, and the identification of acute or chronic public health concerns that may necessitate concentrated research efforts. Certainly some minor fluctuations in the level of funding are to be expected, but stable funding sources are essential to maintain and advance scientific knowledge and health care services.

Federal Funding for Basic and Applied Biomedical Research

Growth in research funding is needed to ensure that a substantially greater percentage of scientifically promising ideas can be explored, the need for intellectual resources and personnel can be met and replenished, research facilities and scientific instrumentation can be modernized, and the research environment of academic institutions can be stabilized.

Growth in basic and applied research funding is needed to meet the challenges of the remainder of this decade, the next decade, and the next century. The HPA specifically recommends that "[f]ederal funding of basic and applied medical research should be increased...[to] a level sufficient to ensure appropriate growth in the nation's biomedical research enterprise." Our goals are consistent with those of the Ad Hoc Group for Medical Research Funding which has made significant concrete funding proposals for the next fiscal year. The major recipients of these increases should be the National Institutes of Health, the Veterans Administration, and the Alcohol, Drug Abuse and Mental Health Administration.

General tax revenues should continue to be the source of federal funding for biomedical research. The use of the recommended increases in federal funding to fortify the nation's biomedical research enterprise should be implemented in two parallel phases. The first phase should concentrate on the restoration of the physical resources (facilities and instrumentation) needed to conduct biomedical research. According to a National Science Foundation study, less that 20% of the existing equipment in the biological and medical sciences used for academic research is "state of the art." [5] Furthermore, many research facilities that were built in the 1960s under a National Institutes of Health matching fund program are now in dire need of modernization. Deficiencies in biomedical research instrumentation identified by the ongoing National Science Foundation study should be addressed by allocation of sufficient funding, and intramural programs at the National Institutes of Health should be strengthened.

The second phase should focus on the rejuvenation of intellectual resources, with an emphasis on increased funding of meritorious grant applications, modification of the renewal grant application system, and support of clinical research faculty under institutional grants. The specifics are discussed below.

Federal Funding of Approved Grant Applications for Biomedical Research

There has been a consistent decline in the funding of grants judged by the peer review process at the National Institutes of Health (NIH) to be of sufficient scientific merit to be approved and eligible for funding. During the first five years of this decade, the percentage of approved grants that are funded by the NIH has slipped from about 50% in 1979 to about 37% in 1984.[6] Repeated and unpredictable reductions in the fraction of total

NIH and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) dollars available for funding grants have led to expenditures at levels below those recommended by peer reviewers. Annual fluctuations in the funding of a number of new and competing renewal awards have the potential to destabilize research careers because of the unpredictability of funding original high quality projects.

Availability of Professionals for Research

The training and continued support of basic researchers and clinical investigators is essential to the advancement of the nation's health care system. Health science education and training programs are critically dependent upon programs and faculties at 270 nonfederal teaching hospitals. The teaching faculty of the academic medical center is the focus of a system that provides the base for highly specialized tertiary care and clinical research into the discovery of disease mechanisms and the delivery of new services.

The federal government makes annual commitments to support research while the academic medical center makes long-range decisions on faculty size and research facilities. However, changing federal priorities, constraints on limited funds, and hospital cost-containment programs have led to a growing concern about the short-and-long-term training and maintenance of biomedical researchers. First, there is concern that the present number of physicians entering research training programs is inadequate. Second, the pool of future PhD biomedical researchers may not be sufficient for the personnel needs of both academia and the rapidly expanding private biotechnology effort. Third,annual fluctuations in federally funded research grants discourage long-term research commitment by new and established investigators. Finally, the maintenance of clinical research faculty at academic medical centers is threatened by economic conditions that necessitate the diversion of faculty time from the conduct of research to the delivery of health care.

It is imperative that basic and clinical biomedical research scientists be available in sufficient numbers to assure the maintenance of the standards and quality, as well as the unparalleled output, of the American biomedical research effort. Further, the high quality of basic and clinical biomedical research faculty at academic medical centers must be maintained both by protecting their research time and enhancing their multidisciplinary research environment.

Funding for and Modification of the Renewal Grant Application System for Biomedical Research

The process involved in applying for grant support can be time-consuming and frustrating. Substantial faculty time is expended preparing the grant proposal and unfunded applications are revised and resubmitted to NIH, ADAMHA, or another funding source. Generally this effort is unproductive with regard to research activity. Additional time is required of the review group to prioritize grant applications.

Longer grant periods provide greater stability for the reseach community and make possible the funding of projects that require extensive laboratory and clinical facilities. Long-range support is necessary for research that requires time to collect detailed data and to assemble and train a highly qualified cadre of clinicians, technicians, consultants, and graduate and postgraduate students.

Although the average length of research grants awarded by the NIH has increased, tight federal budgets have continued to restrict the length of research grants. While shortening the period of research support leads to greater fiscal accountability, it also has led to increasing competition between new and renewal applications. The HPA recommends that "NIH and ADAMHA should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review." The NIH and ADAMHA should review their policy regarding the funding of renewal grants. The length of funding for renewal grants should be increased to a range of five to seven years for those grants that receive a high priority rating from peer review.

Funding for Institutional Grants for Biomedical Research

The support of individual scientists with research project grants has been the first priority of federal support to medical science. In 1960, Congress passed authorization of the general research support fund which permitted the National Institues of Health to allocate as much as 15% of the research budget to institutional grants. This was the forerunner of the Biomedical Research Support Grants (BRSG) program. These grants are awarded to a variety of institutions, including medical schools, graduate schools, and hospitals.

The BRSG program offers alternative means of supporting institutional research and providing clinical faculty more time for research projects. By law, NIH is allowed to spend up to 15% of its budget for institutional research grants, 15-fold more than it currently spends. The HPA recommends that "[t]he support of clinical research faculty from the NIH Biomedical Research Support Grants (institutional grants) should be increased from its current 1 percent." The level of funding for institutional grants should be increased as part of the recommended overall increase in the annual NIH budget for the remainder of the decade. Increases in institutional grants should not be made at the expense of the direct NIH research grants.

Federal and Nonfederal Funding for Biomedical Research at Academic Medical Centers

There has been a decline in funding for research training at academic medical centers in the past decade. In the early 1970s, such funding constituted about 12% of the NIH budget, and this figure has now declined to under 5%.[7] In addition, since 1966, the real level of federal support to the ADAMHA has dropped markedly, even as research opportunities and available scientific personnel have expanded. During the period of liberal financing for biomedical research, many academic medical centers increased their medical school faculty both in the basic scinces and in the clinical departments. As the research dollars began to level off, a considerable number of researchers were shifted to the hospital budget or were subsidized from practice plan revenues. The outlook for continuance of hospital support is jeopardized by competition in the health care system and by the shift to the prospective payment system under Medicare. Centers that rely heavily on practice plan income will soon find that many of their faculty are so busy practicing that they have little time for research, and perhaps even less for students.

HPA recommends that "[t]he academic medical center, which provides the multidisciplinary research environement for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred." The federal government and the American public should be convinced of the importance of these centers. Federal and nonfederal funding should be assured for the maintenance of the research environment and for support of research faculty.

Conclusion

Looking to the future, biomedical research is essential to the continued improvement in the health of the American people, and the nation must have a strong and long-term commitment to it. Biomedical research takes years of patient and often frustrating experimentation by many different research laboratories in both the private and public sectors of the scientific community. Whether an idea originated in a university laboratory or starts with basic product research conducted in the public or private sector, findings are disseminated to the entire scientific community, where each new finding serves as a basis for deeper understanding of human disease and functioning.

For these reasons, the Health Policy Agenda has identified increased funding for biomedical research as one of the highest priorities to improve the nation's health care.

NOTES

[1] Mushkin S., Biomedical Research: Costs and Benefits, Ballinger Publishing Company, Cambridge, 1979.

[2] Glick J.L., "Economic Impact Of Recombinant DNA Technology", in Fudenberg HH, Biomedical Institutions, Biomedical Funding and Public Policy, Plenum Press, New York, 1983.

[3] Norman C., "Broad Public Support Found For Research And Development", Science, 1983, 222:131

[4] National Institute of Health, NIH Data Book 1985, U.S. Department of Health and Human Services, Washington D.C., 1985.

[5] Sun M., "White House Enters Fray On DNA Regulation", Science, 1984; 224:855.

[6] Wyngaarden J.B., "The Construction Of The NIH Budget For FY 1984", Clinical Research, 1983; 32:430-433.

[7] Ibid

STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) wishes to submit the following comments on the President's proposed fiscal year (FY) 1988 budget for the National Institutes of Health (NIH). The ASM is the largest single biological life science society in the world with an active membership of over 35,000. Many of these individuals are engaged in biomedical research and are recipients of awards administered by the NIH.

The ASM considers federal support for fundamental research to be of the highest priority for the national well-being and security. Therefore, we are appalled by the President's proposal to slow down spending for basic research at the NIH. Both the FY 1988 and the revised FY 1987 funding plans reflect a complete lack of understanding and appreciation of the importance of fundamental biomedical research. The President's budget proposal for biomedical research is particularly troublesome since we believe the NIH demonstrably represents the most continuously productive activity of the federal government. Health costs represent an ever increasing proportion of the national budget and the investment in fundamental biomedical research represents one of the most promising avenues for gaining control of these costs. Thus, the continuing attempts on the part of the Administration to reduce the absolute amount spent on basic biomedical research appear irresponsible.

With these considerations, the ASM supports the recommendations of the Ad Hoc Group for Medical Research Funding which proposes a budget of $7,452 million for the NIH in FY 1988 (or $7,690 million with facilities). This proposal represents a current services approach to the NIH budget, plus a relatively modest increase to take advantage of well recognized opportunities for enhancing the research environment and responding to immediate national needs. The increases recommended take cognizance of current fiscal restraints and consequently are well below the needs perceived by both professionals within the government and those in the community at large.

The world is facing an acute health crisis in the form of Acquired Immune Deficiency Syndrome (AIDS). AIDS has been demonstrated to be an infectious viral disease and falls within the area of special competence represented by the ASM. AIDS poses a problem of immense magnitude because of the widespread communicability of the disease and the fact that we have neither a vaccine for protection nor any drug to effect a cure. Thus effective exposure to the AIDS virus constitutes a death warrant. Since millions are at risk in this country, we face an immediate medical crisis which requires major effort to keep under control.

Although recognition of this new disease is only a few years old, we have an extensive amount of information concerning the biology of the virus; vaccines are available for the first clinical testing in humans and already one anti-viral drug has been approved by the Food and Drug Administration (FDA) for treatment. This demonstrated ability to respond rapidly to a new infectious disease, which parallels the previous success with Legionnaires' disease, is a consequence of continuing support for fundamental biomedical research. The three major areas that have played a key role in our success to date are: recombinant DNA technology, virology, and immunology, all areas of scientific investigation heavily represented in the membership of the ASM. Fundamental advances in these areas have resulted in Nobel Prizes to ASM members, H.O. Smith, D. Nathan, P. Berg, H. Temin and D. Baltimore. Recombinant DNA technology has made available reagents which are essential to advances in all areas that are required to identify, understand and combat infection by the AIDS virus. Because the AIDS virus is classified as a retrovirus (a group of viruses which have unique biological properties) and because some of these viruses cause cancer in experimental animals, the viruses were the object of many fundamental investigations long before the first human strains were identified in the past several years. It is the knowledge gained from this previous fundamental research which has made possible current studies of the AIDS virus. The virus particularly attacks the immune system and in order to understand this process a fundamental understanding of the immune system is required. Again, ASM members have played a major role in this area.

Our progress against AIDS has been paralleled in other pressing areas as well. Two other infectious viral diseases which constitute health threats in this country and world-wide are those caused by herpes simplex virus and hepatitis B virus. Again, in both cases we have an increasingly sophisticated knowledge of the fundamental mechanisms by which these viruses cause disease and in both cases, using recombinant DNA technology, vaccines have been produced which are ready for clinical testing in people. These advances, which promise to save billions of dollars every year in health care costs, represent one very narrow sector of the spectrum of research activities supported by the NIH. At many points across the spectrum similar advances have been made with a major impact on the well-being of our citizens. In spite of the documented benefits, the Administration continues to display a severe lack of appreciation of biomedical research.

In our opinion, unfortunately, there is not even a meaningful Administration budget proposal for the NIH for FY 1988. This is because a major portion of the proposed FY 1988 budget resulted from carrying forward a part of the FY 1987 congressionally appropriated budget for the NIH. It appears clear that the Congress is unwilling to accept the recommendation to carry forward these funds and thus, even by the Administration's calculations, other sources of funding for the NIH for FY 1988 will have to be provided.

Therefore, we believe that the only realistic budget proposal that has been put forward is that of the Ad Hoc Group for Medical Research Funding. Approximately a 20% increase in funding for the NIH is requested. This proposal is progressive but modest. Over half of the proposed increase simply represents maintaining the services supported by NIH funding at the FY 1987 level. The actual increases proposed are intended to ameliorate decreases that have occurred in recent years in the ability of the NIH to support basic biomedical research; an area of particular concern is the training of future scientists. Training represents the lifeline of biomedical research and emphasis on this area is particularly important because recent studies have indicated: 1) that the need for scientists is constantly increasing, but, 2) the number of people entering the field of biological research is steadily decreasing at both the bachelors degree level and at the graduate school level. This potential manpower crisis must be avoided.

Also included in the request are funds to improve the opportunities for intramural research at the NIH, the reestablishment of research centers to supplement the efforts of individual investigator initiated research and renovation of the nation's scientific physical plant. This last point is particularly acute with respect to improvement of animal care facilities. With the increasing public sensitivity to the use of animals in research, such improvement of animal facilities constitutes protection against the threat that the progress of research would be severely impeded by the inability to use animals where necessary.

One aspect of the Administration's FY 1988 budget proposal for the NIH does require comment; that is the general notion of multiple year funding. The ASM considers this to be a serious proposal and intends to undertake an in-depth study of this mechanism of funding. On the one hand, appropriate use of multiple year funding could introduce an element of stability into what is now a chronically uncertain level of funding support for biomedical research; on the other hand, if inappropriately applied, such an approach might well provide a mechanism to promulgate underfunding of needed research. Thus, the ASM is committed to looking for ways which might enhance the positive aspects of this mechanism while protecting against the undesirable aspects.

In summary, we consider the President's budget recommendation for NIH to be nonexistent at the moment; thus, we offer the Ad Hoc Group for Medical Research Funding's recommendations instead (see attached proposal). We urge you to increase the investment in the nation's basic health-related research effort at NIH to a level of at least $7,452 million in FY 1988. Even at this level, the percentage of health-related funds devoted to fundamental research would represent a smaller than current portion of our total health expenditures. Health research is absolutely essential to the national interest and must be spared from short-term savings to deal with the current deficit crisis. The economy of the U.S. benefits from the excellence of NIH supported basic research which is often the fore-runner of applied technology. We must maintain our competitive edge in science to ensure a strong economy and scientific research should be one of the nation's highest priorities.

We appreciate the opportunity to comment and stand ready to assist the committee during the budget process for NIH.

STATEMENT OF PEYTON E. WEARY, M.D., AMERICAN ACADEMY OF DERMATOLOGY, INC.

Mr. Chairman, I am Peyton E. Weary, M.D., Professor and Chairman of the Department of Dermatology at the University of Virginia School of Medicine and Washington Representative from the Council on Governmental Liaison of the American Academy of Dermatology. I am also a past Vice-President of the Society for Investigative Dermatology. I am presenting this testimony on behalf of the American Academy of Dermatology, whose membership of over 6,500 represents the majority of American Dermatologists, and on behalf of The Society of Investigative Dermatology, the representative organization for the dermatologic biomedical research community.

We are very grateful for the strong financial support provided by the Congress last year for the new National Institute of Arthritis and Musculoskeletal and Skin Diseases and applaud your recognition that, in order to assure success, a new institute requires careful nurturing. I am pleased to report that it is our perception that this new venture is off to a very good start under the able leadership of Dr. Lawrence Shulman and with the advice and assistance of an outstanding advisory council. The challenge, now, is to maintain, and, indeed, expand upon, this firm base so that the exciting research opportunities which exist in the three mandated areas reach fruition.

We are also grateful to you for refusing to accept the Office of Management and Budget proposal this year which would have "carried over" $339 million from NIH's fiscal year 1987 budget to fiscal year 1988. Your standing firm on this gives us all in the field of biomedical research a great sense of support.

Appended to this testimony is a recent article from the New York Times Magazine which clearly underlines the extraordinary advances in research on the skin and its afflictions that have taken place in the last 10-15 years (Appendix A). Implicit in this is the promise that the exponential increase in our understanding of basic physiologic and biochemical processes in the skin will lead to improved methods of treatment for many of the over 4000 different diseases of the skin which currently are recognized and, furthermore, will shed new light on many internal diseases since the same disordered metabolic processes may produce disease elsewhere in the body. We are particularly pleased that there is a close collaboration and increasing interdisciplinary research with our partners in this new institute which will greatly enhance the productivity of all.

I would also like to take this opportunity to remind the Subcommittee of the fact that our specialty of dermatology has also assumed a position of leadership in the area of prevention and early detection of disease as a result of sponsorship of over 400 skin cancer detection clinics nationwide each year during the past two years and that we hope to expand upon these initial efforts by creating a comprehensive, coordinated and sustained National Program for the Early Detection and Prevention of Malignant Melanoma and Other Skin Cancers over the next few years. To this end, the American Academy of Dermatology is sponsoring an Invitational Conference on May 1 in Washington to focus attention on the need for such a program which seems particularly appropriate at this time when we repeatedly hear about the predicted depletion of the ozone layer and its potential for increasing the threat of skin cancer (see appended Washington Post article, Appendix B).

Mr. Chairman, we have carefully reviewed the projected needs for FY 1988 for the National Institute of Arthritis and Musculoskeletal and Skin Diseases, and we support the level of funding of $196,008,000 proposed by the Coalition of Organizations Concerned with the Programs of National Institute of Arthritis and Musculoskeletal and Skin Diseases (Appendix C). It is projected by the Coalition that 40% of research grants could be funded at that level and, we believe, this is a reasonable and achievable level given the high quality of the grant requests submitted.

We were particularly pleased to note that the Coalition supported the creation of six new core centers for skin disease research and incorporated in the proposed budget a sum of 2.55 million dollars to establish these centers. At present, no core centers exist for dermatological disease. We submit justification for these centers as an appendix to this testimony (Appendix D). I have appended testimony related to the importance of these centers for dermatology. We are also supportive of the need to conduct two clinical trials in skin diseases, one of which deals with epidermolysis bullosa, a disease of which you are well aware. The other clinical trial relates to another inherited skin disorder, ichthyosis, which causes significant problems for a large number of individuals in this country. We believe the opportunities for significant advances in dermatologic research are so great as to clearly justify these new initiatives.

In addition, as we have in the past, we strongly support substantial increases in funding for the National Cancer Institute in which the outstanding Dermatology Intramural Research Program resides. This is particularly important at this time when the threat of a substantial increase in the prevalence of skin cancer and, in particular, malignant melanoma looms so large on the horizon. We are greatly concerned about the exponential increase in malignant melanoma in recent years and the large number of patients who die yearly from this very agressive type of cancer. We, furthermore, suggest that a major increase in funding for the National Institute of Environmental Health Sciences and the National Institute for Occupational Safety and Health are entirely justified to deal with the impact of the ozone depletion and concomitantly a major increase in sunlight exposure and the injurious effects this will have upon the skin.

The threat of AIDS is of great concern to dermatologists since many of the most serious consequences of this dreaded disease are skin-related. We know the Congress is concerned about this and we would strongly encourage a major increase in funding for the National Institute of Allergy and Infectious Diseases to help address this epidemic.

We also have substantial research interests in problems of the elderly, many of whose major complaints are skin related. Some excellent research is already being conducted by dermatologists supported by the National Institute for Aging but much remains to be accomplished and this Institute also deserves your generous support.

Finally, Mr. Chairman, we support overall the recommendations of the Ad Hoc Group for Medical Research Funding.

In conclusion, Mr. Chairman, we wish to express our continuing admiration for the work of this Subcommittee and for their enduring support for biomedical research. It would appear to us that this year, which celebrates the founding of the National Institutes of Health, should also serve as a tribute to the Congress which has expressed its enlightened interest by providing the support to make it all possible. This partnership between the

Congress and the National Institutes of Health has clearly been one of the most productive in the history of mankind and you deserve to be proud of your role in it.

Thank you for the opportunity to testify once again.

(Appendix A and B could not be reproduced and are in subcommittee files.)

Appendix C

NATIONAL INSTITUTE OF ARTHRITIS, MUSCULOSKELETAL AND SKIN DISEASES

IN THOUSANDS

	1986		1987		1988 Coalition	
	No.	Amount	No.	Amount	No.	Amount
Research Grants						
Non Competing	392	$53,346	414	$66,595	421	$75,139
Supplemental		417				400
Competing	199	26,371	179	27,941	320	54,038*
	591	80,134	593	94,536	741	129,577
Research Centers: Spec/Comp	14	9,354	23	18,170	30	27,167
Other Research	69	5,273	70	5,634	99	8,256
Training	223	5,812	280	6,433	375	9,495
R&D Contracts	10	2,339	7	3,327		6,192
Intramural		7,500		6,883		10,321
Management & Support		2,854		3 730		5,000
TOTAL	907	$113,266	973	$138,713	1,245	$196,008

* At this level the Institute will fund approximately 40% of the study section approved grants.

FY 1988 Initiatives

Research Project Grants

- Increasing evidence points to a role for infectious agents in early arthritis.
- Research has determined that osteoarthritis is not necessarily a wear-and-tear disease nor an inevitable consequence of aging. Multidisciplinary studies on osteoarthritis are being planned as a result of a major workshop in this area held in FY 1986. The workshop proceedings have just been published in the December issue of the Journal of Rheumatology. The recommendations of this workshop will provide the basis for a research solicitation to encourage studies on the pathogenetic mechanism in osteoarthritis, to promote epidemiological research studies, and to encourage interdisciplinary investigations.

* Researchers are now learning more about the importance of estrogen, calcium, and exercise in osteoporosis, a major crippling disorder responsible for most of the bone fractures in the elderly. Studies are planned to more fully discern the role of hormones, nutrition, and exercise in treating and preventing this serious disorder.

* Productive research has resulted in increased survivability of patients with systemic lupus erythematosus. However, much remains to be learned about this important serious disease of young women. Investigations to be pursued include research on cross-matching antibodies indicating that lupus may be triggered by environmental antigens, as well as autoantigens; research on immunogenetic determinants; and innovative approaches for immunologic intervention and treatment.

* New, diverse pharmacologic agents have shown great promise in correcting the vascular pathology of Raynaud's phenomenon and systemic sclerosis (scleroderma). At the coalition budget level, a number of research avenues would be followed, including important basic research on microvascular, connective tissue and immunologic abnormalities that characterize Raynaud's phenomenon and scleroderma, as well as mechanisms of action of pharmacologic agents being developed for their treatment.

* Basic research has provided much information on the physiology and pathophysiology of muscles. Additional fundamental research will be encouraged on the structure and function of muscle; this can then be applied to further understanding of muscular diseases and can suggest possible therapeutic approaches.

* Basic studies of muscles, tendons, and ligaments will enable development of improved athletic training programs and optimal rehabilitation programs. Expanded efforts in such basic research studies and their application in athletes, the public at large, and patients are planned.

* The Institute has stimulated interest among the research community in research on low back pain, the most common cause of limitation of activity among persons 17 to 45 years of age. New, multidisciplinary research directions will be pursued on the etiology and treatment of low back pain.

* Recent research discoveries, utilizing monoclonal antibodies, have pinpointed the precise location of cutaneous disease injury responsible for severe blistering of the skin in such tragic, debilitating diseases, as epidermolysis bullosa and pemphigus.

* Recent dermatologic research has now established that the skin is actively involved in immunologic reactions of vital importance, not only for several skin diseases such as contact dermatitis, but also in immune regulation in the body as a whole.

Centers

Many important research advances have been reported by the Multipurpose Arthritis Centers, including development of an excellent new animal model for osteoarthritis; determination of the efficacy of low dose methotrexate in treating severe refractory rheumatoid arthritis; finding that running may not be a risk factor for osteoarthritis; and the potential usefulness of lymphoid irradiation therapy for severe rheumatoid arthritis.

Under the coalition budget, 9 Specialized Centers of Research (SCORs) in arthritis and musculoskeletal diseases, would be continued for $8.1 million. SCORs provide a highly effective means of concentrating research efforts on high priority rheumatic diseases of national importance. These Specialized Centers will conduct needed coordinated basic and clinical research in major disease areas such as osteoarthritis, rheumatoid arthritis, and osteoporosis.

Six new core centers in skin diseases research would be initiated under the coalition budget level ($2.55 million).

Other Research

Careers: Well-trained investigators are vital to fully exploring the important basic and clinical research opportunities available for this new Institute. If these indepth training programs are not appropriately funded, young researchers will be deprived of essential advanced research training opportunities at a critical point in their development; and as a result, may not make the transition to fully independent and productive senior investigators.

Recognizing the great importance of providing these research career development opportunities, the coalition budget would increase the number of competing career awards.

Research Training

The creation of this new Institute at the NIH offers possibilities for greatly expanded research training opportunities in a wide variety of important diseases within the mission of the Institute. Under the coalition budget level, a more complete training program could be encouraged and sustained, with an additional 100 slots (20 individual and 80 institutional).

Contracts

There is a critical need for valid epidemiologic data on important diseases within the NIAMS mission. Epidemiology research contracts studying arthritic diseases in the U.S. would be supported at $2 million under the professional judgement budget. Examples of these epidemiological studies include analyses of existing national longitudinal data on arthritis, musculoskeletal and skin diseases, as well as detailed information on the spine; and analyses of data from the third Health and Nutrition Examination Survey (NHANES III), conducted by the National Center for Health Statistics. This survey will include an extensive section on arthritis and musculoskeletal disorders and bone density studies of osteoporosis.

Three contracts related to osteoporosis in the areas of bone density measurements, functional assessment of knee stability, and reduction of osteoporosis with fluoride in drinking water are provided for in the coalition budget.

Also included in the coalition budget level are two clinical trials in skin diseases: (1) Epidermolysis Bullosa: Efficacy of Dilantin and Treatment of Esophageal Strictures; and (2) the Efficacy of 13-cis Retinoic Acid in Treating Keratinizing Disorders.

Multicenter clinical studies in rheumatic diseases would also be supported; and important, previously recommended, clinical trials in serious connective tissue diseases would be initiated.

Intramural

Intramural research activities in the NIAMS provided many examples of outstanding investigations in the basic and clinical sciences, leading to important advances in medicine. Research accomplishments have been reported from NIAMS intramural laboratories in understanding rheumatoid arthritis, systemic lupus erythematosus, and other types of arthritis, connective tissue disorders; cellular and chemical immunity; underlying processes that produce autoimmunity and the role of autoimmunity in disease; development of inflammation and its role in disease; and structure and function of muscles. Progress in all of these areas is based on multifaceted approaches involving experts in immunology, biochemistry, molecular biology, genetics, and biophysics.

The development of highly productive intramural orthopaedics research activities has been an objective of the NIH for several years. Appropriate, highly capable research personnel have been recently recruited and trained, and are now available for initiating this program. This is a unique research undertaking at the NIH and a strong addition to the research portfolio of the NIAMS.

At the coalition level, it will be possible to plan for new research activities in dermatology.

Research Management and Support

Creation of the new National Institute of Arthritis and Musculoskeletal and Skin Diseases has set in motion a three-year effort to establish a fully functioning independent organization. More than 12 new FTEs have been assigned to the new Institute. Additional new positions and appropriate funds are needed to setup a minimal structure of central administrative functions to serve the extramural programs and intramural research program which have already been transferred to the new Institute.

Appendix D

CORE CENTERS FOR DERMATOLOGY

Organized Dermatology, concerned citizens and the entire investigative constituency of the National Institute of Arthritis, Neuromuscular and Skin Disease urges the Congress to fund 6 Core centers for dermatological research at a cost of 2.55 million dollars in the federal budget for 1988. These Core centers will greatly enhance the productivity of dermatological research and facilitate translation of research discoveries into better patient care and treatment. Furthermore the centers will increase interchange between dermatological investigators and the remainder of the biomedical community; new information developed by dermatological investigators can then be exploited by other biomedical investigators in such diverse areas as rheumatology, infectious disease, cell biology and cancer.

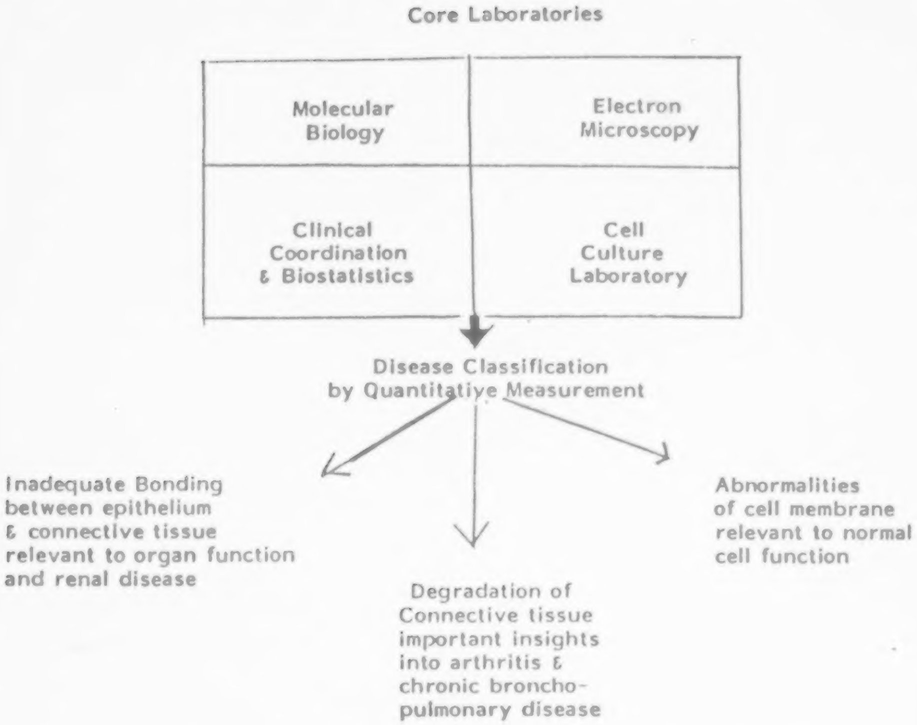
The impact of dermatological disease to American citizens is staggering. One-eighth of all people (22.9 million) have a skin complaint, of which 18.8 million have cutaneous problems which are considered serious. Of the total of 556 million office visits made in 1979, 63 million were for a skin problem. This makes skin disease the fourth most common patient complaint. In 1978 there were 9000 deaths from skin disease. The economic impact of skin disease is enormous. Two per cent of the total national health expenditure is for skin problems. In 1981 this involved the expenditure of 5.1 billion dollars. When the estimated morbidity loss from skin disease (1.5 billion dollars) and mortality loss (200 million dollars) is added, the bill for dermatological disease in the United States is 6.8 billion dollars. These figures do not adequately represent the human toll. Loss of function, discomfort, disfigurement and destruction of self image cannot be measured in dollars.

Dermatological investigation over the past twenty years has reached maturity. The most sophisticated tools of immunobiology have been used to study inflammation in general, eczema, allergic reactions, lymphoma, vitiligo, and of course AIDS. The most sophisticated tools of modern biochemistry have been utilized to study aging and mechanisms of tissue destruction; contributions by dermatologists from this area have been very important in understanding the joint destruction in arthritis. Cell biology has provided insights into cell kinetics and cell behavior pertinent to psoriasis and cancer. Finally, the new discipline of molecular biology has found broad application in Dermatology. Studies of genetic control in epidermolysis bullosa, ichthyosis, and skin cancer have provided unique insights for all of Medicine.

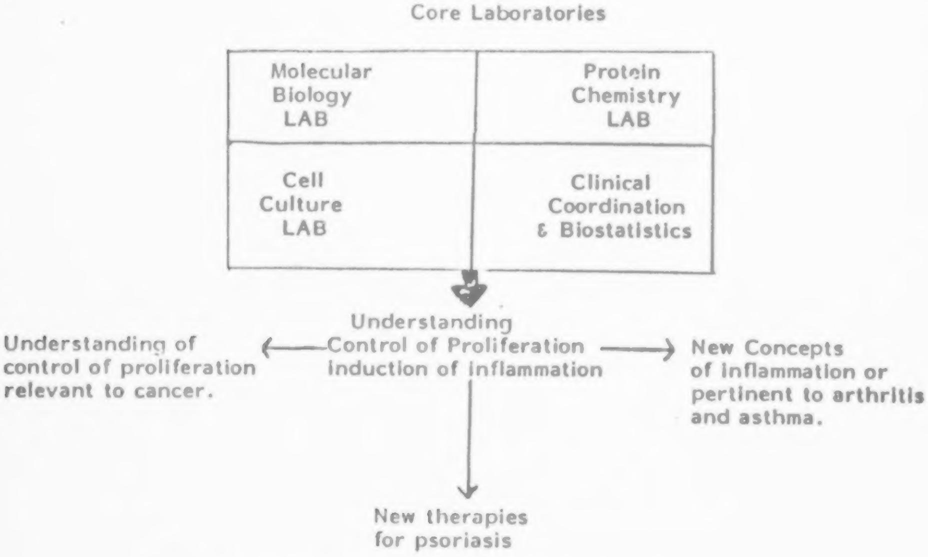
These advancements have led to direct improvements in patient care. Dermatological investigation has led to the development of retinoids for acne, psoriasis and malignant skin disease. Photochemotherapy (PUVA) has provided a unique therapy for psoriasis and pointed the way for the use of light and pharmaceutical agents in the treatment of a wide spectrum of diseases including photophoresis for cutaneous helper T cell lymphoma. Much of the laser technology now presently employed has been developed by dermatologists. Dermatology has focussed the use of corticosteroids in inflammatory disease and defined new therapeutic modalities for the use of these drugs. The importance of skin disease in AIDS has resulted in fundamental immunological, biological and molecular genetic discoveries.

Investigative Medicine needs to establish six Core centers for fundamental cutaneous biological research. These centers, established in programs of great excellence, will provide Core facilities where costly, cutting edge, investigative technology can be brought to bear on a variety of clinical pertinent challenges. Core centers will guarantee maximum utilization of expensive technologies to benefit large numbers of committed investigators. As important the centers will be magnets for interaction between basic biomedical investigators from a variety of disciplines and disease oriented clinical investigators. Core centers will be a shared resource for the investigation of all of the dermatological diseases which have concerned citizen groups e.g. epidermolysis bullosa, icthyosis psoriasis etc. Core centers will have an impact not only on Dermatology but all investigative Medicine. Information will be transmitted to rheumatologists, oncologists, immunologists, infectious disease specialists, so that advances made in Dermatology can have broad impact on the fight against all diseases. The ability of the Core centers to seed preliminary studies will lead to data which can generate peer review research proposals and thus provide new initiatives in the conquest of disease.

The establishment of Core centers for Dermatology in the newly established Institute of Arthritis, Neuromucular and Skin Disease will ensure that all the constituencies of the institute can make major contributions through the center's program.


Core Laboratories
Molecular Biology
Electron Microscopy
Clinical Coordination & Biostatistics
Cell Culture Laboratory
Disease Classification by Quantitative Measurement
Inadequate Bonding between epithelium & connective tissue relevant to organ function and renal disease
Degradation of Connective tissue important insights into arthritis & chronic broncho-pulmonary disease
Abnormalities of cell membrane relevant to normal cell function

The use of highly specialized core laboratories to investigate the genetic disease Epidermolysis Bullosa - Interactions and impact. The results of investigation and implications are based on results already published.


Core Laboratories
Molecular Biology LAB
Protein Chemistry LAB
Cell Culture LAB
Clinical Coordination & Biostatistics
Understanding Control of Proliferation induction of inflammation
Understanding of control of proliferation relevant to cancer.
New Concepts of inflammation or pertinent to arthritis and asthma.
New therapies for psoriasis

The use of specialized high technology core laboratories to investigate psoriasis - interactions and impact. The results of investigation and implications are based on results already published.

STATEMENT OF LUIS GLASER, EXECUTIVE VICE PRESIDENT AND PROVOST, UNIVERSITY OF MIAMI

Thank you for the opportunity to present to you my views with regard to the National Institute of General Medical Sciences.

The National Institute of General Medical Sciences is unique among the Institutes of the National Institutes of Health because it is not associated in a direct way with a particular disease and the problems associated therewith. It is the Institute that serves the most important function of supporting, to a large extent, basic research which represents the underpinnings of biomedical research in this country now and in the forseeable future. An additional and very important mission of the National Institute of General Medical Sciences is the support of training particularly at the pre-doctoral level, although significant support with the post-doctoral level also comes through this Institute.

I am currently the Executive Vice President and Provost of the University of Miami, a post that I assumed in June of 1986. For the last thirty years, I was a biochemist at Washington University School of Medicine, and before moving to the University of Miami, I was the Chairman of the Department of Biological Chemistry at Washington University for ten years, and Director of the Division of Biology and Biomedical Sciences for the last five of those ten years. I have been a recipient of grant support from the National Institute of General Medical Sciences for many years, and I am currently the recipient of a research grant from this Institute that runs until 1989. In addition, I served as the Chairman of the Cell and Molecular Biology of Disease Studies Section, which reviewed for the Institute of General Medical Sciences applications for training grant support at the pre-doctoral level at most of the major universities in the United States.

The research support provided by the National Institute of General Medical Sciences in Molecular Biology and in Genetics has supported the core of our biomedical research for many years and the number of prestigious scientists which have received the Nobel Prize for work originally supported by this Institute is extremely large.

I would like to direct my remarks specifically to the role of the National Institute of General Medical Sciences in the area of pre-doctoral training.

In the last fifteen years the support of pre-doctoral trainees by the National Institutes of Health, and particularly by the National Institute of General Medical Sciences, has remained essentially level in dollar amount. Inflation and the necessary increase in the stipend levels for trainees during this time period, plus the rising cost of tuition, resulted in a dramatic decrease in the number of individuals who can be trained nationally in biomedical sciences.

The recommended levels of trainee support by the committee of the National Academy of Science mandated by Congress have never been met, and have never been met in a particularly sensitive area, the Medical Scientist Training Program, which provides support for the training of recipients of a joint Ph.D-M.D. degree. In recent years the growth of the Biotechnology industry has generated a greater demand for scientists in this area, and universities are finding it increasingly difficult to identify an adequate number of individuals in this area of important research to staff the faculties. The University of Miami is no exception in this regard.

The number of individuals with combined M.D.-Ph.D. degrees who graduated from the most prestigious medical schools in the country in the last year is not much larger than 150, of which perhaps 100 are supported through the Medical Scientist Training Program. When one realizes that these individuals will provide the core of the research to be carried out in clinical departments at all of our medical schools in the country in the forseeable future, we see the magnitude of the problem. The steady decline of physicians engaged in research, as evidenced by receipt of grants from the National Institutes of Health, augers badly for the future of Biomedical research in this country.

A decrease in the number of graduates, Ph.D. or M.D., in any area of science does not immediately translate into a problem in research productivity. A decline in such graduates over a number of years, however, results in a steady and unacceptable decrease in our capablities to carry out basic biological research, and our ability to deal with human disease, as well as our ability to bring the results of basic biological research, through technology transfer, to industry for the development of pharmaceutical products, as well as products of importance for agriculture and the chemical industry. We are now beginning to see the effect of the steady decline in the number of Ph.D. recipients in this country on our efforts in biomedical research and biotechnology.

Because the National Institute of General Medical Sciences is at the center of our research effort in biological sciences both in terms of the research areas supported, as well as in research training, I urge you to provide maximum possible support for this Institute. A steady level of support for our biomedical research efforts in training research and facilities, is essential if we are to maintain the lead that we used to enjoy in biomedical research and biotechnology only a few years ago. The rest of the world is catching up with us rapidly, and only by providing research support, and encouraging the best and brightest of our youth to train in these areas can we hope to compete.

Personally, and on behalf of my University, I would be extremely grateful for your support in this area.

LETTER FROM BETTIE SUE MASTER, PH.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF BIOCHEMISTRY, DIRECTOR, MEDICAL SCIENTIST TRAINING PROGRAM, MEDICAL COLLEGE OF WISCONSIN

April 28, 1987

Mr. Michael Hall
Professional Staff Member
Senate Appropriations Subcommittee on Labor-HHS
Room 186, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Hall:

I am writing as a member of the scientific community to present testimony to the Senate Appropriations Subcommittee on behalf of the National Institutes of General Medical Sciences.

I have been an independent academic scientist since 1968 at which time I left Duke University as a Post-Doctoral Fellow and assumed my first faculty position at The University of Texas Health Science Center at Dallas. I spent the ensuing 14 years as a member of that faculty, being promoted through the ranks from Assistant Professor to Full Professor, performing research in addition to carrying out my teaching duties on the faculty. During those years, I was supported by the National Institutes of General Medical Sciences (NIGMS) for a significant portion of my research efforts. These research efforts were investigator-generated and formed the nucleus of basic observations which have led to some exciting discoveries in my laboratory within the past several years. Since 1982, I have had the privilege of serving as the Chairman of the Department of Biochemistry at the Medical College of Wisconsin in Milwaukee, while maintaining my interests in research and directing an active research program which continues to be supported by NIGMS.

I am very much concerned that the support for basic research continue at the national level for investigators who maintain an interest in and a curiosity about the basic principles underlying the basis of life. I believe that the mission of the NIGMS, while not specifically involved with a disease process, certainly underlies our understanding of life processes in health and, thus, will lead us to an understanding of those processes in disease. The various programs of the NIGMS over the past several decades have led us into the exciting arena of molecular biology and much of the progress in the areas of recombinant DNA technology have derived from these NIGMS-supported studies. This, in turn, has spawned the biotechnology industry and the spin-offs of this original, basic research have led to the development of such products as human growth hormone and insulin. In addition, I would like to emphasize the role which NIGMS has played in research training, since it has been a primary source of funds for the training of research scientists for a number of years. One of these programs, the Medical Scientist Training Program, has had significant impact on the training of M.D./Ph.D. students for academic medicine. Having been involved in this type of program at two institutions, I have some knowledge of its potential impact on medical research in the United States. It is alarming that our youth are turning away in increasing numbers from careers in medicine, teaching and research to careers in business, banking and finance which are perceived by them to be more lucrative and stable.

Therefore, I am writing to present testimony on behalf of NIGMS in the form of a written statement for the Congressional Record.

I appreciate this opportunity to write on behalf of the National Institutes of Health, and in particular, the National Institutes of General Medical Sciences.

Sincerely yours,

Bettie Sue Masters

Bettie Sue Masters, Ph.D.
Professor and Chairman
Director, Medical Scientist Training Program

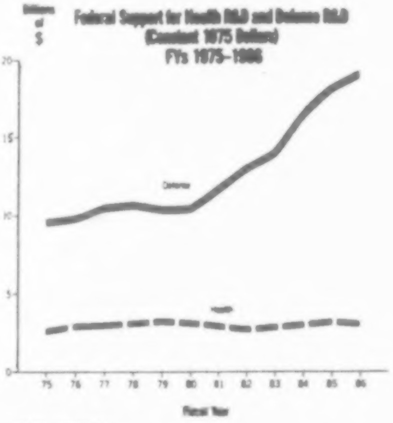
STATEMENT OF BETTIE SUE MASTER

As a member of the scientific community, I am pleased and privileged to present testimony on behalf of the National Institute of General Medical Sciences (NIGMS) of the National Institutes of Health for the continued and adequate support of its programs. As scientists, who feel the excitement of research which drives our dedication to it, we have assumed too often that the importance of our work and its benefits to society are self-evident. I welcome this opportunity to present the case for enhanced stability and increased funding for the vital programs of NIGMS.

Before beginning my testimony, I would like to introduce myself at the risk of revealing that I am an interested party in the outcome of the budgetary issues which you must resolve. In June, 1982, I moved from The

University of Texas Health Science Center at Dallas, where I had progressed through the academic ranks to Full Professor, to the Medical College of Wisconsin to assume the position of Professor and Chairman of the Department of Biochemistry. The Medical College of Wisconsin, located in Milwaukee, is one of two medical schools in Wisconsin, receives capitation funds from the state for 52% of its class, and is a private, free-standing institution. It is also involved in teaching graduate students in seven basic science disciplines. As an academic scientist, I have been continuously funded by NIH since 1970, but I have experienced the ever-increasing frustration and futility of my efforts and those of my colleagues in maintaining an adequate funding level for productive research. I will be speaking from my experiences as a former member of the NIGMS Pharmacological Sciences Review Committee for four years, as an ad hoc reviewer for the Division of Research Grants, the National Heart, Lung and Blood Institute, and the NIGMS for site visits to such institutions as the Massachusetts Institute of Technology, University of California at San Francisco, University of Michigan, and Johns Hopkins and Yale Universities, and until 1986 as Chairman of the Board of Scientific Counselors, National Institute of Environmental Health Sciences. I am a member of a number of scientific societies, including the American Society of Biological Chemists, American Society for Pharmacology and Experimental Therapeutics, and American Chemical Society, having served elected positions in each of them. My students, post-doctoral fellows, and I have all benefitted through the years from the training opportunities made possible through the National Institutes of Health. I would not be in my present capacity were it not for the USPHS predoctoral training program at Duke University which made my graduate training possible in the Department of Biochemistry, then chaired by the late Dr. Philip Handler. Finally, through programs sponsored by the Japan Society for Promotion of Science and the Chinese Academy of Sciences of the People's Republic of China, I have spent periods of time abroad performing research, presenting seminars, and attending symposia on topics of mutual interest. From this perspective, I wish to address the problems of funding of basic biomedical research in the United States.

It is important for us as biomedical scientists to make our plight known as we continue on the roller coaster of off again-on again funding levels translated from congressional appropriations through the Office of Management and Budget into the realities of actual NIH-funded projects. The percentage of grant applications approved by the various NIH Councils has declined from 48.3% in 1976 to 37.3% in 1985 reflecting, in part, the constant level of Federal expenditures for health research and development during that same period (Figure 1, below).



SOURCE: [illegible]

Federal expenditures for health R&D have remained relatively constant, while defense R&D has increased sharply over the past six fiscal years.

Of course, one cannot help but notice the sharp increases in Federal defense R & D during this time (all data are expressed in constant 1975 dollars).

The National Institute of General Medical Sciences, as the only NIH Institute which does not have a disease-oriented mission, has been primarily responsible for the advancement of research in the areas of gene mapping, gene therapy, developmental biology, drug design, research and development in biophysics, and wound healing among others.

The 1986 Nobel laureates, Drs. Joseph Goldstein and Michael Brown, whose basic research on the receptors for low density lipoprotein (LDL) led to increased understanding of the metabolism and regulation of cholesterol, were supported by NIGMS from 1972 to 1977. When these discoveries were found to have profound implications on heart disease, their support has transferred to the National Heart, Lung and Blood Institute. Basic studies of this type, supported by NIGMS, have produced a number of fundamental discoveries.

It is both frustrating and unfathomable that we are being expected to maintain our preeminence in medical research throughout the world with the same level of support provided in 1975 and with severe cuts in the support of training for young scientists through the National Institutes of Health programs. In the remarks to follow, I wish to address the need for stable and adequate research support, as well as funding for training in biomedical research. Increasing the number of trainees is long overdue as the total number of predoctoral and postdoctoral trainees per year supported by NIH has declined since 1979. It should be obvious that training cannot occur in a vacuum and, therefore, requires the continuation of stable and adequate funding for research projects. The National Institute of General Medical Sciences (NIGMS) continues to play a central role in the training of young biomedical scientists by supporting the largest number of predoctoral trainees (56.8% in 1985) of any of the NIH programs and more than five times the number supported by any other Institute (NIH DATA Book, 1986). This support mechanism is vital for the survial of the biomedical research enterprise as it continues to infuse new blood into the system and, yet, 826 fewer trainees were produced by NIGMS alone in 1985 compared to 1979.

It is unquestionable that in the four decades since the enabling legislation by Congress for the establishment of NIH, biomedical research in this country has emerged as second to none. The alarm that many of us feel has forced us from our laboratories and teaching endeavors to speak out for the preservation of this preeminence. We have seen the erosion of biomedical research as a chosen profession for those seeking post-graduate education. The most alarming decrease has been noted in the ranks of the physician-scientist who seeks a career in academic medicine. Since much of the biomedical research directly related to human disease is performed in the nation's medical schools, it is frightening to realize that this has become a lower priority career goal among our youth.

At both The University of Texas Health Science Center at Dallas and at the Medical College of Wisconsin, I have had the privilege of directing the Medical Scientist Training Program (MSTP), which is designed for students who have an interest in clinical medicine, as well as in research in the biomedical sciences. This training program culminates in the achievement of both the M.D. and Ph.D. degrees. This NIGMS-supported program has established an outstanding track record in producing successful biomedical scientists as judged from publication records and ability to compete for peer-reviewed research grant support (On the Status of Medical School Faculty and Clinical Research Manpower, 1968-1990, NIH Program Evaluation Report (1981), U.S. Department of Health and Human Services, pp. 177-193). Unfortunately, the President's 1987 budget calls for a total of 597 individual trainees for the M.D./Ph.D. dual degree program (MSTP). This is 52 fewer trainees than the 1986 roster and 128 fewer than the 725 recommended by the National Academy of Sciences based on manpower needs. Since the Medical Scientist Training Program has been and continues to be one of the most successful projects of the NIGMS in the realm of training activity, it deserves support, at least at a constant level, if not for increased numbers of trainees based on projected needs. It has attracted the most outstanding of students interested in careers in biomedical research and academic medicine and deserves the highest priority by NIGMS and the Congress through increased training support. These students bring the vitality of youth and the freshness of questioning minds to our laboratories and clinics. The frontiers of medicine are continually advanced by the efforts of these young investigators, first, in our laboratories as they are being trained and, later, in their own independent laboratories.

I hope that you will demonstrate your support for increased funding for the National Institutes of General Medical Sciences as the major predoctoral training arm of the National Institutes of Health. This investment in the training of our youth today will reap enormous benefits for this nation's health and well-being tomorrow.

STATEMENT OF PETER A. WARD, M.D., PROFESSOR AND CHAIRMAN, UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

With regard to current appropriations discussions related to the National Institutes of Health and more particularly with reference to the National Institute of General Medical Sciences, I would like to offer my comments as public testimony.

It is difficult to identify an institute that has addressed more effectively the basic biomedical needs of this nation than the National Institute of General Medical Sciences (NIGMS). The term "General Medical Sciences" obscures the vital role the NIGMS plays in the underpinning of support for basic biomedical research and training in the United States. The historical emphasis of NIGMS on research in biophysics, biochemistry, genetics, cell biology and many other areas has functioned as a foundation upon which studies directed toward specific diseases and organ systems have been built. In addition NIGMS has supported the application of basic scientific research to areas of urgent need such as burn and trauma research and the development of new imaging technologies that can be applied at the molecular level in the study of a wide variety of diseases including degenerative, genetic and neoplastic processes that affect multiple organ systems.

At present, science in the United States is at a critical juncture. The continuing and rapid development of probes to identify markers or products of gene activation has revolutionized approaches to scientific investigation. It is clear that many of these new approaches will have immediate clinical application. At the same time, we are in a race with other developed countries for the scientific and commercial deployment of these new probes and applied technologies. As few as two or three years ago it was unimaginable that the use of modern molecular techniques would yield amounts of naturally occurring hormonal factors which can be used in the laboratory and applied to diseases and conditions in humans that do not lend themselves to current therapeutic interventions. Recombinant growth hormone has replaced human pituitary extracts, access to which was extremely limited and beset by problems of viral contamination. In the area of burn and trauma, the costs of which are associated with a loss in the United States of nearly $90 billion annually, the recent advances in tissue culture technology together with the availability of cloned growth factors suggests that it may be possible to cover areas of burn injury with autologous epithelial cells which have been grown in vitro, rather than having to rely on synthetic or incompatible skin grafts. Several studies are currently underway and have demonstrated clinical feasibility of such an approach. The rapidly advancing understanding of the mechanisms by which infectious agents impair host immune and inflammatory defenses in humans who have suffered burn or trauma injury raises the possibility of new therapeutical approaches that will have enormously broad applications in the treatment of human diseases. The extent to which these expectations are borne out could have major economic implications for the country, due to reduced morbidity and mortality and also because of large world markets for the application of these products.

The NIGMS has played an important role in providing support of basic biomedical research, the training of biomedical scientists, and the clinical application of some of the most important and exciting research findings to clinical conditions of humans. The current revolution that is occurring in biomedical science provides NIGMS with an opportunity to play a major role in facilitating the training of young scientists and supporting basic and clinically oriented programs to ensure that the United States will maintain an important lead in scientific progress.

STATEMENT OF C. MAX LANG, SECRETARY-TREASURER, AMERICAN COLLEGE OF LABORATORY ANIMAL MEDICINE

The specialty of Laboratory Animal Medicine was developed in response to a perceived need among biomedical research institutions to train veterinarians in the proper care and treatment of animals used in research. It is noteworthy that the American College of Laboratory Animal Medicine was the second specialty of veterinary medicine. Formally recognized by the American Veterinary Medical Association in 1957, it culminated the efforts of veternarians in the two previous decades to (1) recognize the importance of animals in solving both human and animal disease problems; (2) proficiency in the special training that is required for the care and use of research animals; and (3) the best research data is obtained from healthy animals that are properly cared for in a controlled environment.

The Subcommittee on Labor, Health and Human Services, and Education - throughout these deliberations - will hear and read repeated requests for funding research activities on cancer, heart disease, diabetes, cystic fibrosis, etc. It is important to realize, almost without exception, that these research programs are dependent on animals.

The Congress in the last two decades, has responded to public concerns about how animals are housed, cared for, and used in research. However, the forerunner of these concerns began in the biomedical research community, especially the veternary profession. Members of the biomedical research community have actively worked with the Congress to ensure that these standards are, in fact, understood and implemented. However, it is frustrating because Congress has been hesitant to provide the resources to accomplish the intent of these legislative matters.

The proper care and use of research animals - including using the minimum required and consideration of alternative methods - requires: (1) adequate facilities that will minimize the influence of environmental variables that can complicate the interpretation of research data; (2) trained individuals who can ensure proper and humane treatment of animals, help to protect their health against diseases that could interfere with the successful completion of the research, work with investigators to ensure the use of the best animal model; and (3) adequate diagnostic laboratory capabilities to compliment the diagnostic/treatment skills of those who are committed to the care of those animals.

The proper care and use of research animals is focused, primarily, in one small part of the budget of the National Institutes of Health. I do not mean, by this statement, to belittle the efforts of our primary government agency oriented towards the implimentation of health care - for they are among the best in the world. I only want to emphasize that one small part of our health research budget is oriented towards the animals that enable us to solve those probing questions of human and animal health.

I ask you to focus on two key issues: training of personnel to adequately care for those animals; and adequate diagnostic support to aid in that care.

Training

Shortly after World War II, there were many opportunities for training in the proper care and use of laboratory animals. These included government research laboratories, the veterinary corps of the U.S. Army and U.S. Air Force, and academic institutions. However, these training opportunities have gradually diminished. This is borne out by the number of individuals meeting the requirements for certification as specialists in Laboratory Animal Medicine. For example:

> Prior to 1971, there were 141 individuals who met the requirements for certification as specialists in Laboratory Animal Medicine. Since 1970 there has only been an additional 217 individuals.
>
> Since 1970 - in five year increments - there have been: 1970-1975, 79 individuals achieving certification; 1976-80, 63 individuals, and 1981-85, 63 individuals. We have reached a dangerous - and diminished - plateau, at a time that the need is at its greatest.
>
> The need for trained individuals is at its greatest because research with animals has become more sophisticated and even the smallest change in an animal's environment, or the effects of latent disease, can adversely affect the interpretation of research data.
>
> A large number of specialists in this field are now reaching retirement age. For example, 56% of those individuals certified prior to 1966 have now retired. According to the current trend, it is anticipated that the number of individuals retiring will exceed the number of new individuals entering this important field.
>
> The specialty of Laboratory Animal Medicine is committed to the quality care of research aniamls, but the limitation of trained individuals is becoming a prohibiting factor.

Thus, we urge your favorable consideration of this aspect of the NIH research budget.

Diagnostic Support

The skills of any health professional are dependent on the availability of laboratory diagnostic support. At this time, the National Institutes of Health is only able to support 13 diagnostic laboratories in the entire United States!

The purpose of the diagnostic laboratories are to provide for improved research animal health programs through appropriate surveillance activities and investigation of naturally occurring disease, to support studies resulting in new information on diseases of laboratory animals, to aid in the understanding of new animal models of human disease, and to develop resources for research and training. This focus on laboratory animal disease problems and research with an emphasis from diagnosis, pathogenesis, and control is unique to the Animal Resources Program of the NIH.

Summary

Perhaps we, in the scientific community, have been lax in emphasing our needs. We have supported the Congress in defining the need for quality and humane care of our research animals. However, this can be accomplished only if we have adequately trained personnel to provide such care, and diagnostic laboratory support to enhance the quality of that care.

STATEMENT OF DR. MURRY COHEN, MEDICAL RESEARCH MODERNIZATION COMMITTEE

The Medical Research Modernization Committee opposes the intention of the NIH to use appropriations for FY 1988 for a Chimpanzee Breeding Program. I consider this project to be a waste of taxpayers' money in these austere economic times.

Chimpanzees are used in three major research areas: non A-non B hepatitis, AIDS, and organ transplant surgery. In the first two instances, the animals, although able to produce antibodies to the pathogenic organism, do not develop the clinical syndrome. With regard to non A-non B hepatitis, since chimpanzee research has proven to be unyielding of results which are therapeutic to man, one wonders why it is pursued. With regards to AIDS, Dr. Robert Pollack, in his effort to initiate a national effort to develop a vaccine to counteract the disease, has written: "...there are no animals suitable for initial testing of a vaccine..."; and "In the absence of an animal model for AIDS, such vaccines could not be tested in volunteers, because Government regulations require that new vaccines be first tested in an animal."1 Thus, it appears that the use of chimpanzees in AIDS research actually impedes progress, given the huge population of potential human volunteers.

With regard to organ transplants, the father of, and to this day a great believer in animal organ transplants,2 Dr. Christiaan

Barnard, has written: "I had bought two male chimps from a primate colony in Holland. They lived next to each other in separate cages for several months before I used one as a donor. When we put him to sleep in his cage in preparation for the operation, he chattered and cried incessantly. We attached no significance to this, but it must have made a great impression on his companion, for when we removed the body to the operating room, the other chimp wept bitterly and was inconsolable for days. The incident made a deep impression on me. I vowed never again to experiment with such sensitive creatures."3

Other physicians have raised ethical questions in this area, writing: "It will ... be but a small good if a few human lives are extended for a few years by the use of chimpanzee organs, but it will be a great evil if by so doing we foster the extinction of chimpanzees."4 That the biomedical research community puts small stock in chimpanzee life is clear from the 1984 draft of a national plan to kill those chimpanzees which were no longer needed for research because they constituted "a major economic burden", as well as from the current killing "for safety", with impunity, of those chimpanzees which have been used in AIDS research. This in spite of Harvard Paleontology Professor Stephen Jay Gould's contention that we should "... admit the strict continuity in kind between ourselves and chimpanzees" ... because "differences between the skulls of humans and chimps are quantitative only." Gould goes on to question whether we can "any longer deny to chimps the capacity to conceptualize and to abstract", and he concludes that "... the overall genetic differences are remarkably small." 5

In the past, methods of capture to establish breeding colonies for research purposes devastated whole families of chimpanzees in order to capture infants, thereby further threatening an endangered species,6 and a species whose members live in a complex society resembling our own.7 There is the danger that further support to the breeding colony notion will again result in these kinds of devastations.

Isn't it time to abandon the dead end of chimpanzee research and utilize human subjects to try to conquer some of these elusive diseases? Continued pursuit of "chimpanzee models" would prevent the required commitment of talent, ideas, intellectual energy, innovative methods, new techniques and funds to pursue the human subject clinical approach which could significantly reduce the morbidity and mortality of these dreaded illnesses and conditions.

NOTES

1. For a National Effort to Develop a Vaccine to Counteract AIDS, Robert E. Pollack, THE NEW YORK TIMES, Nov. 27, 1985.

2. Animal Hearts for Humans, Joan Whitlow, THE NEWARK STAR-LEDGER, August 1, 1985.

3. Christiaan Barnard, M.D., GOOD LIFE, GOOD DEATH.

4. Primacy Among The Primates: Killing Chimpanzees To Help Humans, David M. Warshauer, M.D., THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Vol. 254, No. 3, July 19, 1985.

5. Stephen Jay Gould, EVER SINCE DARWIN, W.W. Norton & Company, New York, 1977.

6. New Vaccine May Bring Man and Chimpanzee Into Tragic Conflict, Nicholas Wade, SCIENCE, Vol. 200, pp. 1027-1030, 1978.

7. Jane Goodall, IN THE SHADOW OF MAN, Houghton Mifflin Co., Boston, 1971.

STATEMENT OF ROGER S. FOUTS, PH.D., PROFESSOR OF PSYCHOLOGY, CENTRAL WASHINGTON UNIVERSITY

The National Institutes of Health (NIH) Division of Research Resources (DRR) has initiated a project entitled "Establishment of a Chimpanzee Breeding and Research Program." NIH intends to use appropriations from the FY 1988 budget to continue the project. The following is an evaluation of the feasibility of that program as it is described in the NIH announcement.

NIH established five projects dedicated to breeding chimpanzees and five projects to research the breeding of chimpanzees. The chimpanzees bred at these sites will be used to supply researchers and used as future breeders. The justification for this program presented by NIH is that (1) the wild population is declining, and (2) that out of the 1600 chimpanzees in captivity in this country the breeding population is less than 400 and declining. According to the RFA there will not be sufficient numbers of chimpanzees available in the United States beyond 1987 to assure the establishment of a self-propagating population.

The RFA states that current need for these chimpanzees is as subjects in AIDS research in order to develop and test therapeutic and preventive measures for AIDS, as well as testing vaccines. The chimpanzees bred in these projects would also be used for other types of biomedical and behavioral research and testing.

EVALUATION

Empirical Feasibility:

Critical to the success of this plan is to have a self-propagating population of chimpanzees. As noted, in NIH's RFA (p. 2) the existing population of breeding chimpanzees in this country is declining and that population is presently less than 400. One of the main reasons the present captive population is declining is because second generation chimpanzees do not make good mothers and as a result institutions must depend on wild captured mothers to raise their chimpanzee babies. Wild captured chimpanzees will breed and care for their offspring. The number of existing wild captured chimpanzee females in captivity is declining and eventually the various laboratories will have only a population of second generation chimpanzees that may breed and give birth but will not be self-propagating in the sense of rearing their young themselves. In a 1984 draft of the "National Chimpanzee Management Plan" this very point was made. It stated that very few of the animals in the captivity will

> ...contribute to a dedicated breeding colony. The majority of them, (approximately 680) are aging wild-born animals, and of the remaining captive-born population, very few are proven breeders and parents. Because good parenting behavior is learned during early years from interactions in a social group, those animals separated from their mothers at birth rarely demonstrate

adequate parenting. Poor parenting necessitates separation of the infant from the social group and perpetuates the cycle of inept parents. (1984, p. vii).

The implication of this is that the NIH plan, as described in the NIH's RFA: "... 250 chimpanzee breeders or future breeders will be supported along with OFFSPRING AT THEIR SIDE." (my capitals) cannot become a reality unless the existing problem of poor maternal behavior in captive born chimpanzees is solved.

Until the various existing chimpanzee research laboratories can demonstrate that their second generation chimpanzees will breed and properly care for their young then this present plan is indeed premature.

Fiscal Problems:

The NIH RFA estimates that it will have approximately 250 chimpanzees at an estimated cost per year of $5,000.00 per animal. For 250 chimpanzees the yearly cost (at a bare subsistence support level of $5,000.00 per year per chimpanzee) would be $1,250,000.00 per year. It would be reasonable to assume that if these chimpanzees who are presently NOT breeding in sufficient number are maintained at the present minimum cost ($13.70/per day) then it is unlikely that this will encourage them to breed or develop successful maternal skills any more than they have already.

The fiscal problem related to this is that births will occur to captive-born chimpanzees who do not have good maternal behavior and therefore the infant chimpanzees will have to be removed from their mothers and raised by trained professionals in a nursery. The cost of raising these infants is considerably more than $15.00 a day because of the labor intensive care and contact they will require around the clock not to mention the extra veterinary and dietary considerations. An estimate of the additional cost for this would be an additional $800,000.00 per year.

When the $1,250,000.00 figure for the minimum care for the breeders is added to that of the infants it comes to a total of

$2,250,000.00. The estimate of $2,500,000.00 for each year after the first year would seem to be too low to do much other than keep the chimpanzees alive. The money left would be too little to properly study ways to improve their self-propagating ability.

Research Problems:

NIH has budgeted AIDS monies to support this plan. The latest information in regard to AIDS is that the chimpanzee may not be useful as a subject in AIDS research because they will apparently carry the disease but do not manifest the symptoms commonly found in humans. As a result the chimpanzee could prove to be a disastrous model if used to test AIDS vaccines. For example, a researcher would not be able to determine whether the absence of AIDS symptoms was a function of the vaccine or the chimpanzees' apparent natural resistance. False positives in chimpanzee subjects could have serious consequences for human welfare.

This issue should be resolved _before_ AIDS research monies are used to build these facilities.

Projected Conservation Problems:

The lack of successful self-propagation in the second generation chimpanzees could have a serious negative effect on the declining wild population several years from now. One scenario might be as follows: NIH establishes several breeding projects. The wild captured chimpanzees continue to breed and care for their young. However, as the years pass, their number becomes smaller until only a few remain alive. At this time, the projects will be faced with the same situation they have now. I would conjecture that supporters of the breeding programs at that time would make a strong argument to capture wild chimpanzees in order to give them more time to study breeding and keep the existing breeding population viable. As a result it would be argued that in order to save the captive chimpanzees in this country, we would need to import wild chimpanzees. Please note that this projection is based on the present situation in which the second generation breeding problem has not been solved or addressed.

Projected Societal Implications:

Every research program in the future must address, in addition to empirical considerations, the rational and moral implication of their research. The proposed NIH chimpanzee breeding program will certainly elicit several ethical and rational objections. It could be characterized by its critics as a program that breeds baby chimpanzees so that they can be taken from their mothers and killed as subjects in research projects. Another objection is one that objectively questions the rationality of such a project. Namely, is it rational to kill members of a threatened species, a declining species, in order to increase the population of one that is already suffering from over-population?

Another questions, more of an ethical nature, is: If chimpanzee beings are so biologically (King & Wilson, 1975; Lewin, 1984), and behaviorally close to human beings, then how can we justify killing them and making them suffer? It is well established that the behavior of the chimpanzee is just as strikingly similar to human behavior as are the biochemical and genetic similarities. The work of Jane Van Lawick-Goodall (1968; 1975) has shown us that wild chimpanzee behavior is very similar to that of non-technological groups of humans. Indeed, the wild chimpanzee lives in communities; they hunt; they care for their mothers (even to the extent of mourning themselves to death over their mother's death as the young Flint did when Flo died), they make tools and perhaps most important of all is that they can suffer from emotional as well as physical pain.

In addition to the striking similarities of their culture to ours, they also bear striking cognitive similarities. In the research over the past 18 years by R. A. and B. T. Gardner (1969; 1971, 1978; & 1984) found that chimpanzees have the capacity to acquire human sign language. Other researchers (Fouts, Hirsch &

Fouts, 1982; Fouts, Fouts & Schoenfeld, 1984) have demonstrated that chimpanzees can pass this language on to the next generation and use it to spontaneously converse with each other.

This research on the chimpanzee, as well as other Great Apes, demonstrates that the difference between apes and humans is one of degree. In other words, it supports the Darwinian notion of continuity. This position has been recently extended beyond the Great Apes to animals across the phylogenetic continuum. Donald Griffin (1976) argues that awareness is something that is not limited to humans alone, but shared with other animals. One of the implications of such a position is that the Cartesian position that humans are different in kind from other animals is not supported. It is this Cartesian position that has been an implicit assumption behind much of the animal research for the past 60 years. Non-human animals, in general, have been treated as if they were nothing more than unfeeling machines.

The findings of research from the past 25 years on apes has served to break down this traditional dichotomy between humans and non-human animals. Its implications for animal research are profound. Because chimpanzees are aware, they feel, they have a culture, and are capable of thought then there is a ethical aspect that must be considered when doing any sort of invasive research on chimpanzees.

The implications of this is that the close similarities of chimpanzee beings to human beings is a two-edged sword. These similarities that are so important to biomedical research also raise ethical and moral questions in regard to our species' treatment of our closest living relatives.

There are ethics for research that have been explicitly stated. For example, S.A. Barnett (1981) presents them in his textbook entitled Modern Ethology, The Science of Animal Behavior. He states in regard to any scientific model that it: "... must satisfy three criteria: (a) it must be logical; (b) it must conform to existing knowledge; and (c) it must be morally acceptable to the people of the society in which it is used. A further inevitable feature is that the model must be incomplete: it must admit ignorance." (p. 503). The critical point for this report is "c", that the research must be morally acceptable to the people of the society in which it is used. We must ask ourselves as responsible human beings and scientific researchers, whether or not our society considers the infliction of pain, suffering, deprivation, and death on animals such as chimpanzees a moral act.

Summary:

The main empirical flaw of the present plan is that no successful solution to the second generation self-propagation problem has been developed or addressed. Until second generation chimpanzees can give birth and care for their young, the present plan is premature.

A second empirical flaw is that the chimpanzee may be the incorrect animal model for AIDS research. If so, then is it ethical to use monies budgeted for AIDS research to build breeding colonies of chimpanzees?

A third issue is this program's effect on the conservation of wild chimpanzees if it should fail.

A fourth problem is one which arises when the whole issue is considered from a rational objective point of view: namely, the use of a threatened species in invasive or terminal research.

A fifth consideration is the ethical and moral implications of such research on a sentient and aware species such as the chimpanzee and society's reaction to such use.

RECOMMENDATIONS:

I would recommend that these monies ($4,500,000.00) be used to establish one experimental breeding facility to house about 25 chimpanzees as a social community group. Chimpanzees breed and care for their young successfully in community groups. The reason that second generation chimpanzees in the country are not good mothers is that they may be deprived of essential maternal experiences by their incarceration, early separation from their mothers, and by being kept out of social or community groups. For example, Jane Van Lawick-Goodall (1975) maintains that adolescence (7 years to 11 years) is a very important time for a young female to learn material skills by watching her own mother. The experimental breeding facility could determine this, and if it was successful then the program could be expanded to build several of these facilities for the captive chimpanzees in this country. If properly managed these facilities could also be used to reverse the trend in wild populations by potentially serving as resources with which to return chimpanzees (as an entire established chimpanzee community) to the wild.

REFERENCES

-----Availability of Request for Cooperative Agreement:. RFA 86-RR-01. Establishment of a Chimpanzee Breeding and Research Program. P.T. 34; K.W. 1002002, 0201058. Division of Research Resources. NIH Guide for Grants and Contracts, Vol. 15, No. 4, March 28, 1986.

-----Draft of the National Chimpanzee Management Plan Prepared by Chimpanzee Task Force, Interagency Research Animal Committee, Primate Research Institute, Holloman AFB, New Mexico, April 7-8, 1984.

Barnett, S.A. (1981). Modern Ethology: The Science of Animal Behavior. New York, Oxford University Press.

Fouts, R. S., Fouts, D. H. & Schoenfeld, D. (1984). Sign language conversational interactions between chimpanzees. Sign Language Studies, 34, 1-12.

Fouts, R. S., Hirsch, A., & Fouts, D.H. (1982). Cultural transmission of a human language in a chimpanzee mother/infant relationship. In H.E. Fitzgerald, J.A. Mullins, & P. Page (Eds.), Psychobiological Perspectives: Child Nurturance Series, Vol. III (pp. 159-193). New York: Plenum Press.

Gardner, B.T. & Gardner, R.A. (1971). Two-way communication with an infant chimpanzee. In A. Schrier & F. Stollnitz (Eds.)., Behavior of Non-human Primates: Vol. 4 (pp. 117-184). New York: Academic Press.

Gardner, R.A., & Gardner, B.T. (1969). Teaching sign language to a chimpanzee. Science, 165, 664-572.

Gardner, R.A., & Gardner, B.T. (1978). Comparative psychology and language acquisition. Annals of the New York Academy of Sciences, 309, 37-767

Gardner, R. A. & Gardner, B.T. (1984). a vocabulary test for chimpanzees (Pan troglodytes). Journal of Comparative Psychology, 98, 381-404.

Griffin, D. (1976). The Question of Animal Awareness: Evolutionary Continuity of Mental Experience. New York: The Rockefeller University Press.

King, M.E., & Wilson, A.C. (1975). Evolution at two levels in humans and chimpanzees. Science, 188, 107-116.

Lewin, R. (1984). DNA reveals surprises in human family tree. Science, 226, 1179-1183.

Van Lawick-Goodall, J. (1968). The behavior of free-living chimpanzees in the Gombe Stream Reserve. Animal Behavior Monographs, 1, 163-311.

Van Lawick-Goodall, J. (1975). The chimpanzee. In V. Goodall (Ed.), The Quest For Man (pp. 131-169). London: Phaidon Press.

STATEMENT OF RICHARD W. LINDSAY, M.D., PRESIDENT, AMERICAN GERIATRICS SOCIETY

As President of the American Geriatrics Society, I am pleased to be able to lend endorsement for two appropriations for fiscal year 1988 that relate directly to geriatrics.

The American Geriatrics Society, founded in 1942, is dedicated to improving the quality of life for the aging and aged population with particular emphasis on the dissemination of geriatric medical education and the future delivery of high quality geriatric medical care. The 5,500 members of the Society include a broad representation of clinicians, researchers, and educators in internal medicine, family medicine, and psychiatry. Our primary goal is to improve the care of the elderly through research, education, and innovation in clinical practice.

The Society, through its committee structure, has developed position statements noting the need for increased funding to support fellowship training programs in geriatrics, focusing especially on both the nuances of clinical care for the elderly and the need for basic and clinical research. We believe there exists a definable and growing body of scientific knowledge and new skills that are imperative for competence in the medical care of the elderly.

Attached are copies of our positions on "Education in Geriatric Medicine" and "Research and Geriatric Medicine." Both statements highlight our views. Clinical care, because it is tightly bound to research efforts, can be expected to improve in efficacy and in cost-effectiveness as understanding of disease mechanisms is achieved. Research will not only improve clinical outcomes but can be expected to enhance functional status and ultimately ensure maximal utilization of health care dollars.

We especially endorse the efforts of the National Institute on Aging of the National Institutes of Health in supporting research and research training in geriatrics and gerontology. We recommend appropriations for $238,000,000 to support their important efforts through fiscal year 1988.

We especially wish to support funding of $6,000,000 for training in geriatrics to ensure a sufficient number of teachers and researchers to lead the next generation of geriatricians. Provision for this was made under the 1987 Omnibus health legislation as P.L. 99-660S.1774, which is also contained under Title VI of the Public Service Act of the President's budget request for FY 1988.

The nature of chronic illnesses and the resultant decrease in autonomy as one ages affect the way medicine is practiced. Our educational training programs will, by necessity, shift to some extent from the acute care hospital setting to include the nursing home and community. The need to have well-trained, senior faculty, which includes physicians, academicians, and researchers, in geriatric medicine is an absolute.

STATEMENT OF THE MEDICAL LIBRARY ASSOCIATION

The Medical Library Association is a professional organization of about 5,000 individuals and institutions involved in the management and dissemination of biomedical information in support of patient service, health education, and research. We are most appreciative of past support the committee has shown the biomedical information community, and welcome the opportunity to submit testimony in support of appropriate FY 1988 funding for the National Library of Medicine (NLM).

Medical libraries throughout the country have an important stake in the outcome of your deliberations on the National Library of Medicine's budget, because NLM's goals and programs have a profound effect on our own. The National Library of Medicine is, as its name indicates, a NATIONAL library, and serves as the cornerstone and focus of this nation's biomedical information management system. The results of its programs and services reach beyond Bethesda, beyond the national network of medical libraries across the country, to health care providers, researchers, patients and students everywhere.

The proposed budget before you would provide $2 million less than necessary to cover even the most basic library and information services of the NLM. Although the Medical Library Association recognizes the need for fiscal responsibility, we are convinced that the President's proposed FY 1988 is not adequate. Without your intervention, medical libraries and their information-seeking clients throughout the U.S. stand to suffer. We ask your support for a budget of $89 million dollars, which includes 10 million dollars for the biotechnology information center described by Mr. Pepper in HR 393.

Recently, the Library completed its long range plan, developed under the auspices of its Board of Regents. The Plan is a remarkable synthesis of ideas, generated during fertile discussions among scores of experts from a wide array of disciplines, including leaders from the Medical Library

Association. Besides clarifying the NLM's primary mission, it offers an exciting vision of the future, and an outline of the challenges facing medical librarians if that vision is to become a reality. The budget must begin to respond to the critical needs and opportunities addressed in the Plan.

The library community looks to the National Library of Medicine's continued leadership in dealing with the problems of preservation of biomedical literature--in fact all scientific literature. In a recent hearing sponsored by the NLM's Board of Regents, our Association's president discussed the distressing evidence that scientific works in our libraries are printed on paper that is deteriorating. Using more permanent paper in publishing represents an excellent preventive measure, but research must continue if we are to preserve the scholarly record of the past for future generations.

In addition to preserving the scholarly record, we must continue to ensure its accessibility and usefulness. The Regional Medical Library (RML) program administered by the NLM has been an invaluable tool for facilitating access to biomedical literature for health professionals. Through resource sharing arrangements, this network processed some 2 million loans of library-based materials last year. In addition, special initiatives within the program have supported the development of electronic linkages between rural practitioners and urban-based libraries, ameliorating some of the damaging effect of geographic isolation.

Our national commitment to research has generated an enormous amount of new knowledge. In the past 50 years, we have invested over $50 billion dollars in quest of medical knowledge through the National Institutes of Health, but only one half of one percent of that amount for managing and disseminating that information through the National Library of Medicine, and less still for retooling libraries in the field. As a result, medical librarians often find themselves using what are essentially stone-age systems to manage space-age information.

To build supple, sophisticated systems to manage biomedical information, a major research and development initiative is needed in the area of knowledge management. A special infusion of resources is required in at least five areas.

1. New technologies offer a variety of options for the storage and retrieval of information, including optical disk storage and display devices, workstations, electronic conferencing systems, and database management programs. At this time, only about half of the 120 academic health sciences libraries in the U.S. have their catalogs or other local databases available online. For hospital libraries, the number is less than 5%. Our health information centers must be retooled to utilize these technologies creatively and effectively.

2. Medical libraries must be transformed into health science information centers, electronically linked to classrooms and auditoria, patient care sites and health care offices. With information captured and stored in machine-readable form, dissemination to the bench, boardroom, or bedside is possible on demand. As the Integrated Academic Management Information Systems (IAIMS) initiatives supported by NLM have already shown, on and off-campus access to library databases is important strategically as well as academically. Continued support is needed to advance the development and deployment of these integrated networks.

3. In addition to network linkages and sophisticated systems, the health information center of the future needs software that facilitates gathering, restructuring and disseminating information from multiple online database sources, both from within and outside the institution. The online environment offers new ways to access and retrieve information, but requires special software development to manipulate full-text databases beyond simple "page-turning" techniques. New programs must accommodate graphics, like radiographs, sketches, and gene maps. They must be able to move a query among related texts and

files, rather than requiring the information seeker to learn complicated and dissimilar command languages. Software must be developed that helps the scientist create and manage personal knowledge bases in personally-meaningful ways.

4. To inform the design of the systems and software, basic research is needed in the area of medical information science. We must better understand how information is used in health care settings to know how to deliver it. We must analyze how researchers gather and integrate information to know what knowledge management tools to design for them. We must trace formal and informal channels of information transfer to know which databases to link together. We must examine the ways knowledge is represented before we can establish pathways for traversing it. Through the Medical Informatics and Unified Medical Language initiatives, the National Library of Medicine has already begun to answer some of these questions, but expanded support is crucial at this juncture.

5. Progress on these fronts depends upon the existence of highly skilled medical science information specialists. Existing medical librarians must be retrained, and a new profession of medical knowledge managers and researchers must be educated. In addition to developing and using knowledge management tools, these professionals must be prepared to train health care center personnel to use them effectively. Demonstration projects and training initiatives must be funded to begin this work.

Representative Claude Pepper recently introduced H.R. 393, to establish a biotechnology information center as a component within the National Library of Medicine. The center would store biotechnology information, build links among existing databanks, and create computerized systems to allow scientists around the United States to share the molecular genetic information coming from the nation's laboratories. Current efforts at mapping the human gene present an information management challenge of monumental proportions, one that incorporates all of the issues outlined here. The Medical Library Association believes that the National Library of Medicine is uniquely suited for this endeavor, and supports Mr. Pepper's bill. We strongly support the introduction and swift passage of a similar bill in the Senate.

Through its long range planning process, the National Library of Medicine has provided medical libraries with a challenging vision. Through its intramural and extramural programs, NLM provides support and encouragement for our efforts to shape the future. It is essential that basic library and information services are fully supported, and that the medical library assistance programs be strengthened to pursue the initiatives identified in the long range plan. The Medical Library Association urges this committee to support a budget of $89 million for the NLM, including $10 million for the proposed biotechnology information center.

STATEMENT OF HENRY HOOD, M.D., PRESIDENT, GEISINGER FOUNDATION

I am Dr. Henry Hood, President of the Geisinger Foundation which is located in Central Pennsylvania. Each year, more than 29,000 people are hospitalized at Geisinger owned or managed hospitals and facilities. More than 600,000 outpatients visited Geisinger physicians last year alone. Geisinger research efforts are an integral part of a comprehensive, multi-institutional system of health care that serves a region encompassing nearly 22,000 square miles.

On behalf of my colleagues at Geisinger, let me state our appreciation of this opportunity to present our views to this Committee on fiscal year 1988 appropriations for the National Heart, Lung, and Blood Institute (NHLBI).

I would like to preface this statement by emphasizing that Geisinger enthusiastically supports the activities of the National Institutes of Health, particularly NHLBI and its various programs pertaining to heart research. We at Geisinger unequivocally support the Institute's commitment to fund the entire spectrum of research, both basic and applied; both for treatment and prevention. Under the able guidance of Dr. Claude Lenfant, that commitment continues.

Geisinger believes research is an essential component of medical advancement. Our staff members participate in clinical and basic research programs investigating cardiovascular, renal, malignant, and gastrointestinal diseases. In the cardiovascular area, Geisinger's researchers have pioneered studies involving a new hormonal receptor system in the heart.

Moreover, groundbreaking ceremonies in Danville, Pennsylvania -- adjacent to the Geisinger Medical Center marked the first step in a $60.0 million research initiative that will bring together senior investigators studying cellular and molecular biology. The early work of researchers in this area -- focusing on cardiovascular disease -- could lead to the development of drugs to treat coronary artery disease or to prevent the onset of hypertension.

It is well known that cardiovascular disease is prevalent among Americans, young and old. Cardiovascular diseases afflict more than 60 million people and cause almost one million deaths each year. Some 58 million persons suffer from hypertension, 6 million from coronary heart disease, and 2 million from cerebrovascular disease. Cardiovascular diseases are responsible for a loss of about one hundred billion dollars each year in productivity, wages and medical costs. Given this human suffering and economic consequence, it is imperative that NHLBI resources be expanded so that the current initiative in cardiovascular research can be maintained.

Geisinger's recommendations are aimed at maintaining this initiative. The desirability of exercising fiscal austerity should not supercede NHLBI's resources to continue its efforts in combatting the full panoply of cardiovascular diseases: hypertension, cerebral vascular disease, coronary heart disease, arrhythmias, heart failure and shock, congenital and rheumatic heart diseases, cardiomypathies and heart and circulatory system-infection.

To carry out its program, the Institute uses different mechanisms to accomplish specific objectives, including investigator-initiated research project grants -- the mechanism used to support most of the basic and clinical research that makes up the knowledge acquisition portion of the research continuum. Another important complement to research supported by investigator-initiated project grants is the Research Centers Program.

The Institute's Specialized Centers of Research (SCOR) programs in heart, lung, and blood diseases provide a unique environment for concentrating resources, facilities, and multidisciplinary expertise to conduct basic and clinical research. These center programs are designed to produce rapid clinical applications of basic science advances. They continue to be successful.

An example is the Institute's Hypertension SCOR Program. Hypertension remains a major risk factor for coronary artery and cerebrovascular disease. Through its hypertension SCOR's and investigator-initiated research project grants, the Institute is pursuing promising research leads on the basic mechanisms that regulate blood pressure, including the role of neurobiological factors, and elements in the diet such as sodium, calcium, potassium, and amino acids. This research may increase the chances of controlling hypertension through diet and other nonpharmacologic measures.

Although the NHLBI has made considerable progress in the cardiovascular area, the battle against these diseases is far from over. New information should be used to learn new insights about cardiovascular diseases. Indeed, the Institute is pursuing several promising areas of basic research.

The recent revolution in recombinant DNA technology has opened doors for research that were inconceivable a few years ago. Investigations of genetics with the use of sophisticated DNA and monoclonal antibody techniques have had a significant impact on heart, lung, and blood research. Research to develop new pharmacological interventions continues to produce new knowledge.

Geisinger enthusiastically supports this ongoing research, and we applaud NHLBI supported research that has contributed to such achievements as open heart surgery, cardiovascular and respiratory intensive-care units, diagnostic instruments for use in lung disease, and elimination of hepatitis B as a transfusion hazard.

Furthermore, we at Geisinger encourage the Institute to continue its prevention, education, and control efforts, particularly those programs that seek to reduce the prevalence of such risk factors as smoking, hypertension and elevated cholesteral levels. The Institute's emphasis on prevention and continued support for basic research through individual project grants and research centers that makes prevention possible will continue to have a positive impact on death and disability that results from diseases of the heart, lung, and blood.

Given the demonstrated economic soundness of biomedical research activities, increased appropriation levels for NIH, and particularly NHLBI, should be a national priority. Geisinger believes that in order for NHLBI to be able to continue to fulfill its mandate and provide the leadership which is crucial to our national biomedical research effort, an appropriation of 1.4 billion is necessary for fiscal year 1988.

In closing, I would like to quote Dr. Harold L. Foss, Surgeon-in-Chief of Geisinger Medical Center from its beginning in 1915 to 1958. Dr. Foss once said, "Medicine is never static; its leaders can never enjoy the luxury of inertia." These words are as true today as they were back in 1915. Medical research cannot stand still. The Federal Government must not turn its back on biomedical advances of the future which could yield billions of dollars in health care savings.

On behalf of my colleagues at Geisinger, I thank you again for allowing us this opportunity to present our views.

STATEMENT OF MELVIN MARTIN, PRESIDENT, AMERICAN ASSOCIATION FOR RESPIRATORY CARE

I am Melvin Martin, President of the American Association for Respiratory Care (AARC).

On behalf of the AARC, I am submitting these views for inclusion in the formal hearing record. AARC is the 27,000 member national professional organization representing approximately 100,000 respiratory care practitioners in this country. We appreciate this opportunity to share our views with this Committee on fiscal year 1988 appropriations for the National Heart, Lung, and Blood Institute (NHLBI).

I would like to preface this statment by endorsing the activities of the National Institutes of Health, particularly NHLBI. AARC wholeheartedly supports the Institute's commitment to support the entire range of research. I believe our country's investment has been rewarded several times over.

Under the excellent leadership of Dr. Claude Lenfant, NHLBI continues to achieve success in the fight against cardiovascular and cardiopulmonary diseases. AARC's recommendations are aimed at maintaining that momentum.

Although we recognize the strains that have been placed on the federal budget in recent years, the fact that diseases of the heart and lungs continue to pose the most serious threat to our nation's health must not escape us.

Eighteen million Americans suffer from chronic lung diseases. Lung diseases, in fact, account for 47 percent of all deaths under one year of age. Thus, diseases of the lung are the sixth leading cause of death in the United States.

In the area of lung disease, the NHLBI focuses on six major areas: the structure and function of the lung; emphysema and chronic bronchitis; pediatric pulmonary diseases; fibrotic and immunological interstitial lung disease; respiratory failure; and pulmonary vascular disease.

As respiratory care practitioners, we have daily experiences with the effects of these lung diseases on people. We therefore applaud the work being done in these areas.

Given the demonstrated economic soundess of biomedical research activities increased appropriation levels for NIH, and particularly NHLBI, should be a national priority. AARC believes that in order for NHLBI to be able to continue to fulfill its mandate and provide the leadership which is crucial to our national research effort, an appropriation of $1.4 billion is necessary for fiscal year 1988.

The Federal Government must not turn away from the biomedical advances of the future which could yield billions of dollars in health care savings. On behalf of the AARC membership, I would like to thank you for affording us the opportunity to present our views.

STATEMENT OF THE UNITED SCLERODERM FOUNDATION, INC.

Mr. Chairman, I am Diane Williams, a scleroderma patient and founder of the United Scleroderma Foundation, Inc. I am happy to be here to present this testimony on behalf of all scleroderma patients. The United Scleroderma Foundation was organized 11 years ago and at that time I knew of no other scleroderma patients. I now count thousands of them as friends. Knowledge of our disease was lacking; but through the United Scleroderma Foundation, scleroderma literature was printed, workshops were presented, and a public awareness program was instigated. Knowledge was the key word! We no longer feel isolated with a disease nobody understands. In a like manner, I hope your generous research funding will continue, and through the knowledge gleaned by researchers, we may all look forward to the day we can announce a cure for scleroderma.

Scleroderma literally means "hard skin", but the many and varied symptoms of the disease can affect the entire body. The localized form affects the skin and underlying tissue and bone, while the systemic form can affect the skin and internal organs. The skin of the face can be drawn tight, giving a mask-like effect, and oral hygiene becomes a problem as the mouth will not open properly; skin on the hands also tightens with resulting crippling; circulation too, becomes a problem, and cold and stress can bring on a spasm with color changes in the extremities. This is called Raynaud's phenomenon, and is experienced by 98% of patients. Ulcerations occur on the fingers, and are difficult to heal, while other infections are the result of calcium deposits breaking through the skin. Amputation may be necessary when circulation and infections cause gangrene. The spasms and scarring down are also seen internally in the esophagus, heart, lungs and kidneys; and are considered extremely serious in the vital organs.

Many of these symptoms make it difficult for the person to continue in their job. Pounding a typewriter can be agony and crippled fingers make it an impossibility. Air conditioning can cause the spasms of Raynaud's, and any slight bump can cause unsightly, painful finger ulcers.

There are an estimated 600,000 persons in the United States who are afflicted with scleroderma. The many facets of the disease, its involvement of muscle, joint, and internal organs, as well as skin, fit all categories of the arthritis, musculoskeletal and skin institute. Hence, the United Scleroderma Foundation is a fitting member of the Coalition of Patient Advocates.

Scleroderma research is on the increase. In 1976 the late Gerald P. Rodnan, M.D., who was known as the "Father of Scleroderma" was participating in a panel discussion attended by several hundred interested physicians at an International Symposium on Rheumatic Diseases. He was amazed at the interest being generated in scleroderma research and treatments. He spoke of the increasing number of research papers being submitted for publication and how only a few years earlier he could not have gathered more than a dozen physicians to discuss the disease.

In retrospect his comments were but a prediction of things to come. Investigative interest has been on the rise, but exceeds monies available. The Academy of Dermatology and the American Rheumatism Association turn away research and clinical presentations at their meetings due to time constraints. Those presentations which are accepted are heard by standing room only crowds of physicians and interested researchers.

The increased interest in the disease, its etiology and treatment spurs more questions and avenues for research. The

United Scleroderma Foundation has had an impact in bringing scleroderma to the attention of both patient and the public and provided an avenue for increased knowledge and understanding of the disease. We have witnessed strides made in improved treatment. We have seen a medication become available for combatting one of the most critical of scleroderma problems, "Renal Crisis", and as a result many lives have been prolonged.

Our request today is for funding of NIAMS in the requested amount of $196,000,000. A part of these requested funds would be utilized in establishing six dermatology research centers. We wholeheartedly support this concept of "Centers", having seen the benefits derived from similar "Arthritis Centers" previously funded through N.I.H. We believe in "striking while the iron is hot". The interest and desire exists. It is imperative that monies necessary to support this interest and desire continue and increase. Although our dollars are small, the United Scleroderma Foundation will continue to further its support of research. It would be ideal not to look to government for revenue and we do believe in support from the private sector; yet, we know the change in tax laws will make it more difficult for lay organizations to gather necessary funds. Government must take an even greater role in supporting medical research.

We are grateful for the support you have provided in the past and have seen its benefits. We look forward with the other organizations represented here today, to continuing progress. The interest of researchers exists. We must not let it wane. As I said, knowledge is the key and your support of the NIAMS budget request will unlock the answers to improved patient care and the eventual eradication of disease like scleroderma.

My sincere appreciation for the time allowed me to speak to these important issues.

STATEMENT OF WILLIAM BALISTRERI, M.D., DIRECTOR, DIVISION OF PEDIATRIC GASTROENTEROLOGY AND NUTRITION, CHILDRENS HOSPITAL MEDICAL CENTER, CINCINNATI, OH, ON BEHALF OF THE NORTH AMERICAN SOCIETY FOR PEDIATRIC GASTROENTEROLOGY

Mr. Chairman and Members of the Subcommittee, as Past-President of the North American Society for Pediatric Gastroenterology and a member of the National Digestive Disease Advisory Board, I am pleased to present my perspective on digestive diseases in children.

The number of Pediatric Gastroenterology and Nutrition subspecialists has expanded significantly over the past 10 years. There are now approximately 70 training programs whose graduates number approximately 30 per year. Members of our subspecialty address several needs: (1) maintaining health (i.e. nutrition) during the critical period of development of the gastrointestinal tract, and (2) managing specific disease entities. Our subspecialty was founded on the premise that the digestive tract of children has a distinctive physiology and is affected by unique diseases. Our patients are not "small adults", therefore research into mechanisms and treatment of digestive diseases in adults may not be applicable to children. These aspects must be recognized so that we can institute effective management which will allow the child to attain his/her full growth and developmental potential. Practitioners of our subspecialty treat patients with disease similar to those seen by our colleagues in internal medicine, such as inflammatory bowel disease and chronic active hepatitis. These diseases, however, have features and complications particular to the pediatric population.

Despite the recent increase in the number of trainees entering the subspecialty, manpower and research needs are still not being met. This is reflected by the continual, energetic recruitment of graduating trainees by university departments and by independent hospitals. In most medical centers, diseases of the digestive system rank second in frequency to respiratory infections.

In parallel with the need for an increase in the number of practitioners, intensified investigations directed toward basic and clinical questions must be carried out. A central theme must be to understand alterations in development of digestive tract structure and functions which are associated with the enhanced susceptibility of the immature digestive system to exogenous insults as well as various specific disease entities. In fact, immaturity of function, in and of itself, is an important area of study. Aspects of cell biology, perinatal gastrointestinal tract physiology, and biochemistry must be interrelated so that factors crucial to the nutritonal care of premature infants can be outlined. With these concepts in mind, improved methodology suitable for a study of infants and children may be developed.

The clinical entities which are referred to a specialist in Pediatric Gastroenterology and Nutrition are broad in scope. Currently, the major, frequently encountered problems are:

(1) **Provision of nutrition** for the low-birth weight infant and maintenance of nutrition for infants who have suffered a catastrophe in early life which, has led to loss of a critical length of the intestine. In both of these common situations the infant has impaired ability to digest and to absorb nutrients. The latter entity, termed the "short bowel syndrome", is currently managed by provision of nutrients through parenteral (intravenous) routes. The only hope for survival in these infants depends on an increase in the absorptive capacity of the remaining bowel, namely compensatory growth of the unaffected segments. The recent refinements in the techniques of parenteral alimentation (i.e provision of the entire caloric need by vein) has allowed for improved survival of neonates in whom adequate oral feeding is not possible. However, there is a major complication of this modality - the development of liver disease with cirrhosis. This will occur in direct relationship to the duration of the parenteral infusion and is especially frequent in

premature infants. Better understanding of the needs of vulnerable infants may allow the administration of appropriate nutrients and trophic substances which may more rapidly induce adaptation of the immature gut of the premature infant as well as the damaged gut of the infant with intestinal disease.

(2) The two most common forms of **liver disease** in the infant, termed neonatal hepatitis and biliary atresia, are enigmatic. We currently have no firm data as to their cause and have no specific methods of treatment. These diseases are common, occurring in approximately 1 in 4,000 live births. Their impact on the child and family is great; the financial burden is large and the lack of information is difficult for affected families to accept. The only hope for survival for children with progressive disease is liver transplantation. Since affected infants are young and undersized, surgical techniques and recruitment of donors matched in size is difficult. Approximately 40% of these die while awaiting transplantation. Study of the mechanisms of pediatric liver disease may lead to recognition of specific anti-viral agents or drugs which could prevent progressive heopatobiliary dysfunction.

(3) **Gastroesophageal reflux**, a very common disorder in the newborn period, can have serious consequences. There is significant morbidity, with complications such as pneumonia, failure to thrive, anemia, cessation of breathing, and damage to the esophagus. The cause of this disorder is unknown, however, alterations in development may be responsible. Better understanding of gastrointestinal function may allow rational use of drugs to decrease the incidence and impact of gastroesophageal reflux.

(4) **Cystic Fibrosis**, which occurs in an alarming frequency (1 in every 2,000 live births) is also not specifically treatable. Affected children die of lung, heart, liver or intestinal complications. We, as pediatric gastroenterologists are frustrated by our inability to provide consistent, effective

nutrition or to manage the liver manifestations (gallstones, cirrhosis, bleeding) attendant to this disease.

(5) **Congenital enzyme deficiencies**, which lead to impaired absorption from the gut or improper utilization of nutrients by the liver, are managed at present by feeding specifically designed formulas. This is only partially effective.

(6) **Infectious Diarrhea**, the major cause of infant mortality in underdeveloped countries, must be more precisely investigated. A clear understanding of the intestinal response to injury as well as the intrinsic defense mechanisms is crucial to management and prevention.

Mr. Chairman, the day-to-day management of each of these diseases is a challenge for pediatric gastroenterologists. Practitioners of our subspecialty have voiced their commitment to address these issues on several fronts. Precise definition of the scope of these problems, achieved through careful epidemiologic studies is a first step. Education and training of young subspecialists in our field will create a "critical mass" effect which will provide the time and the environment for meaningful research. There is, at present, little outside financial support for training programs in Pediatric Digestive Disease. Consistent attention to research issues must be fostered so that new information regarding prevention and treatment will emerge. We need your support. I thank you for the opportunity to provide this testimony.

Funding Recommendations for Fiscal Year 1988
DIGESTIVE DISEASE NATIONAL COALITION

A. Overall NIH: $7.4 billion in accordance with the Ad Hoc Group for Medical Research Funding.

B. National Institute of Diabetes, Digestive and Kidney Disease: $609 million. This level of funding would provide a modest growth rate for the institute and provide for the stabilization of the centers programs.

C. Digestive Disease Division: $250 million of the institutes funding for the Digestive Disease Division of NIDDK. This level would represent a degree of parity among the institute priorities.

D. Digestive Disease and Nutrition Centers Program: $13.1 million. This level of funding would allow the NIDDK to continue the meritorious Digestive Disease and Nutrition Centers research grants currently being funded, and allow for modest expansion.

E. DD Advisory Board: $350,000. The outstanding efforts of the DD Advisory Board should be funded at a rate very similar to other advisory boards.

F. Epidemiology and Data System: $4.5 million. To support the substantial effort being conducted to establish liver transplant data, endoscopy data, and basic digestive data and information.

G. National Digestive Disease Education and Information Clearinghouse: $500,000. To support the current outstanding efforts to provide education and information to thousands of patients, family members and professionals concerned with diseases of the digestive system.

H. Specific Funding for Training of Research Specialists: $13 million. Allocated specifically to enable the NIDDK to keep our best scientists in academic medicine working on digestive disease problems. The DD division has numerous meritorious applicants, and under current constraints only a few can be funded and no Research Career Development Awards can be funded. This recommendation is consistent with recommendations made by the report submitted to Congress by the National Institute of Diabetes, Digestive and Kidney Diseases.

STATEMENT OF DENHAM HARMAN, M.D., PH.D., EXECUTIVE DIRECTOR, AMERICAN AGING ASSOCIATION

Mr. Chairman, Ladies, and Gentlemen: My name is Denham Harman. I am Executive Director of the American Aging Association (AGE).

I appreciate the opportunity to testify on behalf of the American Aging Association before the Subcommittee on Labor, Health and Human Services, and Education of the United States Senate on the need to increase support in the National Institute on Aging for basic biomedical aging research directed to determining the process(es) responsible for aging.

Aging is the progressive accumulatin of changes produced by the aging process. These changes are responsible for the ever-increasing likelihood of disease and death with advancing age. As a result each species has a maximum life span characteristic of the species; this is illustrated schematically in Figure I for mouse, dog, horse and man - the dashed line also shows what might happen if the aging process were slowed in man.

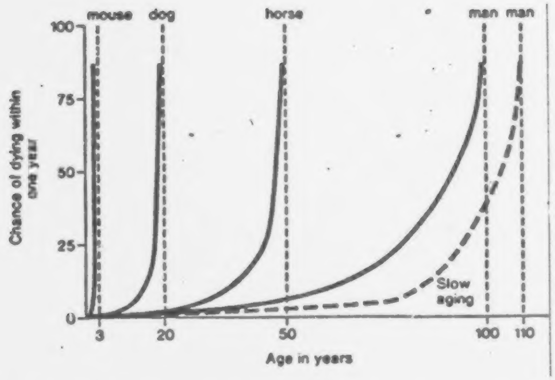


Figure 1. Chance of dying as a function of age for mice, dogs, horse and man as well as the curve that might result if the aging process were slowed in man.

The contributions of the aging process to disease and death, small in the early part of life, increase progressively with age and eventually becomes the dominant factor determining the age of death.

The chance of dying in the United States in 1985 as a function of age is shown by the dashed line in Figure 2. This curve is the resultant of the

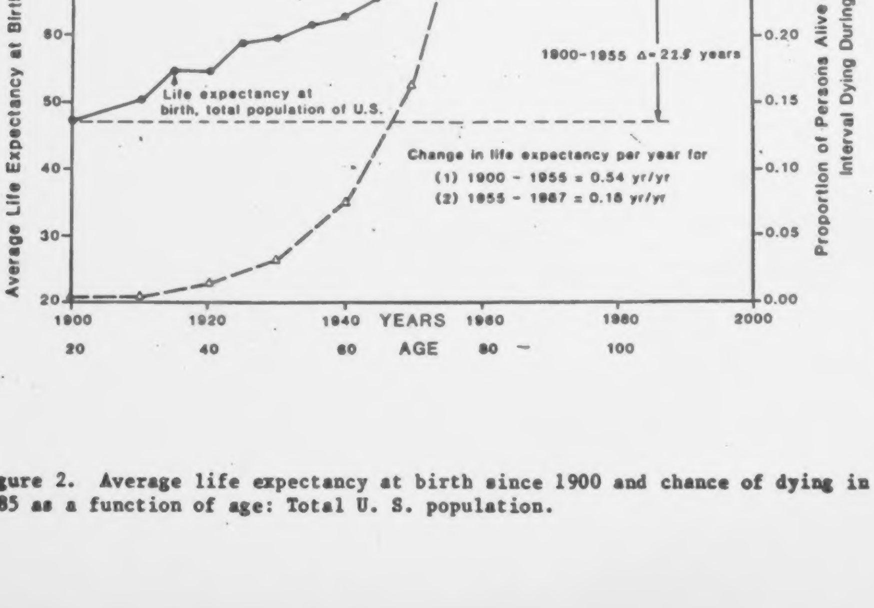


Figure 2. Average life expectancy at birth since 1900 and chance of dying in 1985 as a function of age: Total U. S. population.

effects of the environment, diseases, and of the changes produced throughout our bodies by the aging process. In earlier periods the corresponding curve was higher in the first part of life and displaced to the left in the later years as illustrated (Figure 3) by similar data, although plotted on a semi-log plot, for Swedish women for various times from 1751-1790 to 1941-1950. Improvements in nutrition, housing, medical care, public health facilities and accident prevention gradually decreased "premature deaths" and shifted the curve towards the present location. As a result, average life expectancy at birth (ALE) - a rough measure of the span of healthy productive life - increased steadily as shown in Figure 2, , from 47.2 years in 1900 to 69.7 years in 1954-1955. After 1954-1955 the rate of increase began to slow reaching 74.8 years in 1987. Apparently at about 70 years of age the ever-increasing widespread changes produced by the aging process begin to progressively thwart efforts to further reduce premature deaths so as to limit ALE to about 75-76 years; this plateau value for ALE is about nine years less than the value to be expected in absence of overt disease.

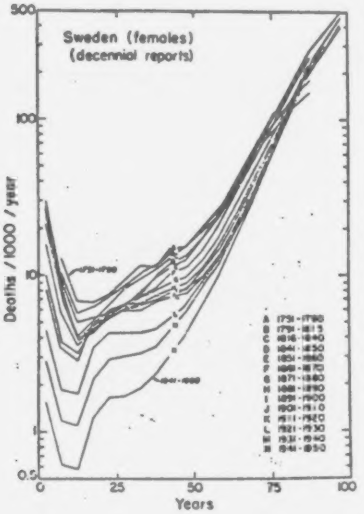


Figure 3. Age-specific death rates of Swedish females in various periods from 1751 to 1950.

The aging process is now the major cause of death in the United States and the developed countries. This fact is obscured by the protean nature of the contributions of this process to the events, e.g., cancer, heart attacks, strokes, which terminate life. In all probability, significant increases in ALE in the future will be achieved only by slowing the aging process. The nature of this process is in dispute. Until there is a consensus it is unlikely that a major effort will be made to slow the rate of aging. The importance of significantly increasing our healthy life span beyond the present value of 74.8 years warrents a markedly increased effort by the National Institute on Aging to determine the cause(s) of aging and to utilize that knowledge to our benefit.

STATEMENT OF LEONARD D. GOODSTEIN, PH.D., EXECUTIVE OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee, I am Dr. Leonard D. Goodstein, Executive Officer of the American Psychological Association (APA), representing the 87,000 members of APA. I am pleased to submit testimony addressing fiscal year 1988 appropriations for the National Institutes of Health (NIH), the Office of Educational Research and Improvement, (OERI) and the National Institute on Disability Rehabilitation Research (NIDRR).

NIH RESEARCH BUDGET

APA strongly urges the Subcommittee to increase funding for research at NIH to $7.69 billion in FY 1988. The National Institutes of Health are 14 separate agencies that together represent the nation's largest source of funding for biomedical and behavioral research. We greatly appreciate this Subcommittee's support of the research conducted by NIH and urge you to reject the Administration's request of only $5.534 billion in new budget authority for NIH in FY 1988. This request, which would fund only 5,654 new and competing research grants in FY 1987 and 5,700 such grants in FY 1988, directly contravenes Congressional intent to maintain a level of support for research projects that would keep pace with the rapid growth in new research opportunities. APA's recommendation, and that of the Ad Hoc Group for Medical Research Funding, would permit NIH to fund roughly 7,000 new and competing research grants in FY 1988.

HEALTH AND BEHAVIOR

Last year, the Committee expressed in its report accompanying the FY 1987 NIH appropriations bill its interest in and support of "research funding by NIH on the role of behavioral and social influences in health promotion and disease prevention". APA believes that the Committee's directive that each of the research institutes should consider increased support of health and behavior research is sound scientific and public policy. It has been well documented that many health problems, including heart disease and cancer, are linked to behavior that can be described as health-impairing. Two recent reports, the Surgeon General's report "Healthy People" and the Institute of Medicine's report "Health and Behavior", document that seven of the ten leading causes of death in this country are in large part behaviorally determined and can be reduced significantly through changes in behavior. As a result of the Committee's interest in this matter, NIH has submitted a report indicating that its support of health and behavior research increased by $40 million to a total of $147 million in FY 1986. This amount, however, still represents less than 3 percent of NIH's overall research and research training budget. Given the importance of behavioral factors in health promotion and disease prevention, APA recommend increasing the percentage of NIH funds allocated to health and behavior research. Smoking or heavy drinking; poor diet; lack of exercise; delay in seeking medical care; and failure to comply with treatment and rehabilitation regimes all are examples of health-impairing behaviors and have great influence on the success of efforts to understand and promote good health and prevent disease.

NIH RESEARCH TRAINING

APA recommends a substantial increase in the number of research trainees supported by NIH in FY 1988. In contrast, the Administration's budget plan for FY 1988 calls for supporting 10,867 full-time research trainees - the same number supported in FY 1987. An investment in the production of scientists who will provide the new ideas for the next generation is one of the best investments that this nation could make to improve the health and productivity of the American public. A 1985 report of the Institute of Medicine (IOM) on personnel needs for biomedical and behavioral sciences advocated increased federal support for training in these disciplines, and called for increased federal support at the predoctoral level in behavioral research. We urge the Subcommittee to specifically direct NIH to implement the recommendations of the IOM to increase funding for predoctoral research training support in the behavioral sciences.

BIOMEDICAL RESEARCH SUPPORT GRANT (BRSG) PROGRAM

APA believes that the restoration of funding for the Biomedical Research Support Grant Program in FY 1988 should be a high priority for Congressional consideration. The BRSG Program provides flexible support to augment the research resources of institutions engaged in health related research. Support for new investigators, innovative research projects and techniques and multi-disciplinary research are activities that can be financed under the BRSG Program. We urge that the Administration's budget proposal to terminate the BRSG program, now funded at $59.9 million, be rejected.

LABORATORY ANIMAL SCIENCES AND PRIMATE RESEARCH (LASPR) PROGRAM

APA supports funding for the Laboratory Animal Sciences and Primate Research Program at $63.7 million in FY 1988. The LASPR Program is the NIH office that funds the resources necessary for research involving both laboratory animals and their alternatives. Recent changes in statutes and regulations governing the use and care of research animals has led to a need for more funding to keep the seven Regional Primate Research Centers and other animal research facilities in compliance with the regulations of NIH and the Department of Agriculture's Animal and Plant Health Inspection Service.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

APA strongly recommends that the Subcommittee support an increase to $502.4 million for the NICHD in FY 1988. The NICHD was established as part of NIH with the rather unique mandate of conducting and supporting research promoting the healthy development of children, from the prenatal period into adulthood. Unlike other components of NIH, NICHD does not focus on disease entities but, instead, supports important research on the psychological, social, biological and environmental factors that influence the course of normal and atypical development. Current research emphases at NICHD include childhood injury prevention, adjustment in families with mentally retarded children, teenage sexual activity, pregnancy and childbirth, and behavioral and biological factors associated with normal and high-risk pregnancy and birth. New initiatives planned by NICHD include studies special of the health risks faced disproportionately by minority children, especially studies examining the relationship between lifestyles and health, and research on the impact of AIDS and Aids Related Complex in children on their development and on their families. We also urge the Subcommittee to encourage NICHD to comply with past Committee report language directing NICHD to strengthen their commitment to behavioral science research by allotting a larger percentage of grants and grant funds to behavioral and social science research on child health and development.

NATIONAL INSTITUTE ON AGING (NIA)

APA strongly recommends that NIA's FY 1988 research budget be funded at $248 million in FY 1988. The National Institute on Aging is the major source of federal funding for behavioral and social, neuropsychological, and biomedical research in aging. At a time when the aging population in this country is increasing and when NIA has reorganized its extramural research program to better address important areas of aging research, the Administration has submitted a budget request for FY 1988 of $167.2 million, a $9.8 million reduction in the NIA budget from the FY 1987 level appropriated by Congress. If these proposals are enacted and valuable research on Alzheimer's disease; studies of cognitive aging and changes in intelligence, learning ability, memory and sensori-motor functioning; and behavioral geriatric studies into health promoting behaviors and the reduction of urinary incontinence would be compromised.

OTHER NIH INSTITUTES

APA recommends that significant increases in FY 1988 appropriations be approved for the National Cancer Institute, National Heart, Lung and

Blood Institute, National Institute of Environmental Health Sciences, and for NIH Buildings and Facilities (for the new NICHD/neuroscience-primate facility), and that these institutes allocate an increased share of their budgets to health and behavior research. Health and behavior research is especially relevant to the prevention of cancer, cardiovascular, blood and lung diseases, and to the expansion of our knowledge on the health effects of exposure to toxic subtances.

OFFICE OF EDUCATIONAL RESEARCH AND IMPROVEMENT (OERI), DEPARTMENT OF EDUCATION

APA recommends that Congress support the Administration's FY 1988 proposed funding level for OERI of $70.2 million and the request to earmark $1 million for field-initiated research activities. These additional funds are needed to identify and better understand factors contributing to major educational problems, national education trends and policy issues.

NATIONAL INSTITUTE ON DISABILITY REHABILITATION RESEARCH (NIDRR), DEPARTMENT OF EDUCATION

APA urges the appropriation of $52 million, the full authorized level, for the NIDRR in FY 1988. As the leading federal institute mandated to promote, coordinate and disseminate information on handicapped research, NIDRR supports vital research on the rehabilitation of handicapped individuals and on engineering advances, which influence and enhance the quality of life of disabled persons. We urge the Subcommittee to support an appropriation at this level to provide increased support for new research initiatives, independent investigator research grants, additional centers, peer review, and an improved information dissemination program.

Thank you for the opportunity to present the views of the American Psychological Association on these important appropriations issues.

STATEMENT OF THE PAGET'S DISEASE FOUNDATION

The Paget's Disease Foundation is pleased to once again have the opportunity to present its statement in support of appropriations for the National Institute of Arthritis and Musculoskeletal and Skin Diseases. As in previous years, we speak on behalf of the estimated three million Americans who are afflicted with Paget's disease of bone, and the health professionals who work to alleviate their distress.

Paget's disease of bone is the nation's number two bone disease, after osteoporosis. It is present most frequently in a mild form, and is often misdiagnosed as arthritis. However, when Paget's disease progresses it can cause devastating pain and crippling.

Because Paget's Disease affects mainly senior citizens, these patients also must endure many of the other sicknesses and disabilities of the elderly as well as the economic problems which the elderly must deal with. Because the drug therapies used to treat Paget's Disease are very expensive,the cost of properly managing the disease is often an impossibility for the patient,

Excerpts from recent letters dramatically tell of the hardships Paget's patients suffer.

"Having the disease for 30 years and living with pain daily makes me feel like there is no hope for relief. At 77, I wish for a day or two of no pain. On a small pension and with the cost of care, there is no contribution to spare...".

"Due to heavy medical, drug and hospital expense I am unable to send a contribution - - - please continue me on the mailing list. It is time more doctors and others understand this dread disease - Paget's."

"Our father had Paget's and died at 50 - a complete cripple. My sister and I both found out we had it when we were in our 40's. - - I have 4 children and 10 grandchildren ... I would hate to think they would have to hurt like I have and still do."

"I have Paget's Disease and my medical bills are such that I can't even keep up with them."

Paget's disease has been recognized since 1878, but there has been no cure or help for it until recently. Through research, some underwritten by the the National Institutes of Health, several drug therapies have been developed which appear to slow down the progress of the disease and alleviate its symptoms.

These drug therapies, however, are far from a panacea. As physicians have worked with them during the past ten years, they have found that numerous patients do not respond to them satisfactorily. Physicians are looking now to more effective forms of the drugs to be developed. At the same time, they are seeking to learn the cause of the disease, and to better understand the patient population which the disease affects.

The only current NIH grant for Paget's disease research is to explore the possibility that it may be caused by a slow-acting virus, similar to that causing other diseases such as AIDS. There are very few other researchers working on Paget's disease today, largely, we feel, because the resources for funding grants appear to be highly limited. Also, because the disease has a low profile in both the the public sector and the scientific community, major research focus has been concentrated elsewhere. The Paget's Disease Foundation is working hard to improve the Paget's research situation, mainly through the National Institute of Arthritis and Musculoskeletal and Skin Disorders and also with the support of the private sector.

The Paget's Disease Foundation was formed 10 years ago to help patients and physicians learn about the disease and its new therapies. Because the disease has been so often misdiagnosed or dismissed by physicians, we estimate that only about 200,000 patients are under treatment for their disease.

The Foundation has mounted and will continue to aggressively mount on-going public awareness campaigns to reach more patients who need help. Also, we are greatly expanding our efforts to reach and work with the medical practitioners who treat these patients.

The work of the NIAMS is vital to us, and we urge that Congress appropriate adequate funding for the Institute to maintain its ongoing programs. We have joined the Coalition of Organizations Concerned with Programs of the NIAMS to urge that $196,000,000 be designated for the FY 1988 budget. Any amount less would be disastrous to those in the field who are already operating under crisis conditions.

In the past Congress has made possible remarkable advances in biomedical research through its support of the NIH. We hope that the Centennial Celebration of the NIH will marke a renewed dedication by the Congress to solving the mysteries of those diseases such as Paget's disease of bone which cause so much pain and suffering.

Again, we thank you for allowing us to speak on behalf of Paget's disease patients.

STATEMENT OF PHILIP J. LANDRIGAN, M.D., PRESIDENT, ASSOCIATION OF UNIVERSITY PROGRAMS IN OCCUPATIONAL HEALTH & SAFETY

My name is Philip J. Landrigan, M.D. I am Professor of Community Medicine and Director of the Division of Environmental and Occupational Medicine at the Mount Sinai School of Medicine in New York City. Also, I am President of the Association of University Programs in Occupational Health and Safety, the organization representing the nation's fourteen Educational Resource Centers (ERCs) in occupational safety and health.

The Current Status of Occupational Disease in the United States.

Occupational disease is widespread in the United States. In New York State, which contains approximately 8 per cent of the nation's workforce, a recent study indicates that no fewer than 5,000 to 7,000 deaths result each year from occupational illnesses. Occupational illness is therefore the fourth leading cause of death in New York (after heart disease, cancer, and stroke). In addition, this study estimated that at least 35,000 new cases of occupational disease develop each year in New York State as the result of work-related exposures. Extending these findings to the nation, it is clear that work-related disease remains a major problem in the United States despite the passage seventeen years ago of the Occupational Safety and Health Act, which sought to "insure safe and healthful working conditions" for every working American.

Why do occupational diseases remain so highly prevalent in the United States? Why, in 1987, do instrument makers in New York City suffer acute mercury poisoning? Why do farm workers in Texas, California and other states continue to suffer and die from acute pesticide poisoning? Why do miners in West Virginia, Ohio, Indiana, Kentucky and Illinois continue to suffer the ravages of coal workers' pneumoconiosis, "black lung" disease? Why do foundry workers across the United States continue to die from silicosis, a disease which has been recognized since biblical times? Why do workers in the semi-conductor industry in Massachusetts suffer an increased rate of reproductive loss, apparently as the result of workplace exposures?

Reasons for the Persistence of Occupational Disease.

A series of factors combine to account for the persistence of occupational disease in the United States.

First, too little is known and too little is being done to learn about the potential toxic effects of synthetic chemicals. A recent study by the National Academy of Sciences found that no information is available on the toxicity of approximately 80 per cent of the 48,000 chemical substances currently in commercial use. Even for substances which are most closely regulated - drugs and foods - reasonably complete information on toxic effects is available for only a small minority of agents. Premarket evaluation of new chemical products under the Toxic Substances Control Act (TSCA) is notoriously inadequate.

Second, the Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) have in the past six years become increasingly ineffectual protectors of occupational health and safety. The budgets of these two agencies have been cut drastically by the current Administration. NIOSH today is operating with less than 50 per cent of the budget that it had in 1980. OSHA inspectors make more paper inspections today than six years ago, but seldom do they visit factories or conduct actual field inspections. In the meanwhile, the Office of Management and Budget (OMB) has shown substantial unwillingness to approve research or to foster protective regulation in occupational health. A recent study conducted by the Mount Sinai School of Medicine and the Harvard School of Public Health found that OMB was seven times more likely to disapprove funding for research in occupational and environmental health than in all other areas of public health and preventive medicine.[1]

Finally, and most relevant to our discussion today, there exists a severe shortage of adequately trained professionals in occupational health and safety. Occupational physicians, occupational health nurses, industrial hygienists and specialists in occupational safety are all in short supply. A consequence of this shortage of trained personnel is widespread underdiagnosis and misdiagnosis of work-related disease. In 1985, for example, it is estimated that approximately 3,700 cases of occupationally-related cancer occurred in New York State.

In that same year, however, only three awards for occupational cancers were made in the state under the workers' compensation program. Although many factors contribute to this gross disparity, a major underlying issue is the inability of most physicians to recognize work-related disease when they see it.

The average medical student in the United States receives only four hours of training in occupational medicine in the four years of medical school.

Occupational histories are recorded on only approximately 10 per cent of hospital charts in the United States.

Annual costs of occupational disease in New York State alone are estimated conservatively to be over six hundred million dollars (in 1985 dollars). Thus, in the United States, the total annual cost of occupational disease exceeds six billion dollars. A major consequence of the underdiagnosis of occupational disease is that these costs are largely uncompensated. Most costs of occupational disease must be borne directly by sick workers and their families, or by third party insurance systems, employers, or trade unions. Workers' compensation programs contribute less than 10 per cent to the costs of occupational disease.

Reduction in the costs of occupational disease and proper assignment of these costs to workers' compensation programs will not be possible until there is an adequate supply of trained professionals in occupational health who will properly diagnose occupational disease and initiate appropriate curative and preventive measures.

The Educational Resource Centers (ERCs).

The Educational Resource Centers (ERCS) were established by Section 21(a) of the Occupational Safety and Health Act. In 1976, Congress authorized NIOSH to create 20 multidisciplinary ERCs, regionally located at major universities throughout the country. Funding of each of these centers was envisioned to be at least 1.0-million dollars per year. Development began in 1976, and by 1980, a funding level of 12.9-million dollars permitted support of twelve centers. In 1980, over 100 different academic programs were active in these centers, offering degrees in occupational medicine, industrial hygiene, occupational health nursing, and occupational safety. The number of graduates in the ERCs virtually quadrupled from 1976 (176 graduates) to 1980 (747 graduates). Even more dramatic was the increase in continuing education programs offered to practicing professionals to upgrade their skills. In 1976, approximately 1,600 individuals attended such courses; by 1980, this number had increased to almost 10,000 persons.

Since 1981, funding for the ERCs has decreased drastically. Each year from 1981 through 1987, the Administration proposed elimination of the ERCs and elimination of the NIOSH extramural training budget. This year, the Administration has requested seven million dollars for the ERCs, but has stated that this budget request represents the beginning of a threeyear phase-down which will "allow an orderly transition to other governmental and private funding sources." Additionally, the Administration has proposed that 2.4-million dollars of the monies currently available to the ERCs be reprogrammed to the Food and Drug Administration (FDA) "to partially fund their pay raise and employee retirement system."

Each year, since 1980, the Congress has seen fit to resurrect the ERCs from the ashes of Administration policy. Thus, in 1981, the Congress maintained a funding level of 8.7-million dollars. In 1982, the budget was 5.8-million dollars.

In 1984 and 1985, despite the additional attempts of the Administration to eliminate the ERC programs from the budget, Congress restored funding to a level of 8.7-million dollars. In 1986, funding was further reduced by the Gramm-Rudman-Hollings Bill to 8.4-million dollars. In 1987, funding was raised by the Congress to 9.9-million dollars.

The effect of the Administration's policies in regard to the ERCs has been drastic. Rather than fostering an "orderly transition", the Administration's policies have led to a disorderly hemorrhage of scarce resources.

The decrease in funding has had a significant effect on training programs throughout the country. Two years ago, the University of Arizona was unable to maintain a full multi-disciplinary program and lost their ERC funding. The number of graduates in all of our prgrams has fallen drastically. This is indicated by the graphs and charts which are appended to this testimony.

The locations of the current ERCs are as follows:

o	Alabama	School of Public Health University of Alabama in Birmingham.
o	California	School of Public Health University of California, Berkeley.
		Institute of Safety and Systems Management University of Southern California.
o	Ohio	Institute of Environmental Health University of Cincinnati
o	Massachusetts	School of Public Health Harvard University.
o	Illinois	College of Medicine University of Illinois in Chicago.
o	Maryland	School of Hygiene and Public Health The Johns Hopkins University.
o	Michigan	Center for Occupational Safety & Health Engineering The University of Michigan.
o	Minnesota	School of Public Health University of Minnesota.
o	New Jersey	School of Public Health Robert Wood Johnson (Rutgers) Medical School.
o	New York	Department of Community Medicine Mount Sinai School of Medicine.
o	North Carolina	School of Public Health University of North Carolina, Chapel Hill.
o	Texas	University of Texas Health Sciences Center School of Public Health, Houston.
o	Utah	Rocky Mountain Center for Occupational and Environmental Health, University of Utah.
o	Washington	School of Public Health & Community Medicine University of Washington at Seattle.

Rationale for Continuing Support of the ERCs.

The rationale for continuing to train professionals in occupational health is two-fold: (1) that occupational diseases are highly preventable; and (2) that prevention requires skilled diagnosis, thoughtful intervention and experienced follow-through of a sort that can only be provided by highly skilled professionals.

Occupational diseases are a major public health problem. They are not rare; they are not restricted to a limited number of factory workers exposed to exotic hazards under unusual working conditions. Deaths and illness due to occupational disease are widespread in the United States and have the potential to affect citizens in every community throughout this nation.

Occupational diseases encompass a broad range of human illness. They include lung cancer and mesothelioma in asbestos workers, cancer of the bladder in dye workers, leukemia in workers exposed to benzene, chronic bronchitis in workers exposed to dusts, disorders of the nervous system in workers exposed to solvents, chronic kidney disease in workers exposed to lead, premature senility in workers with chronic exposure to neurological toxins, heart disease in workers exposed to carbon monoxide, impairment of reproductive function in men and women exposed to lead and pesticides, and chronic disease of the musculoskeletal system in workers who suffer repetitive trauma.

Occupational diseases are extremely expensive. Annual costs exceed six billion dollars.[2]

Against this enormous burden of pain, suffering and fiscal expenditure, we seek the sum of 9.9-million dollars for support of the nation's ERCs. The 14 ERCs and the other graduate and under-graduate programs supported by NIOSH through their extramural training budget constitute the nation's thin line of defense against occupationally-induced disease. Without the ERCs, occupational illness can only become more common. Without the hard work of the dedicated professionals trained in the ERCs, silicosis would be even more rampant than it is today, asbestosis would continue, occupational lead poisoning would blight the children of another generation of workers, and discovery of the toxic hazards of newly released chemical compounds would be made only after more workers had been injured and killed by those chemical compounds.

Support for continuation of the ERCs is widespread.

- The labor movement has always given unstinting support to the ERCs.

- The American Occupational Medical Association, which represents 4,000 physicians practicing occupational medicine in the United States, the majority of them in corporate settings, supports the effort of the ERCs to train professionals in occupational health; attached to this testimony is a letter of support by T. Forrest Fisher, M.D., President of the American Medical Association.

- Politicians on both sides of the aisle have strongly supported the ERCs. Two years ago, in Senate hearings to investigate a suspected excess in cancer mortality due to chemical exposures at the Hill Air Force Base in Utah, Senator Orrin Hatch stated "if there is a villain in this controversy, it is ingnorance; ignorance of the proper methods relating to the protection of the employees from harmful chemical exposures; ignorance of the scientific knowledge related to the effects of the worker's exposure to chemical substances; and ignorance of the now accepted fact that occupational causes of disease and illness often go undetected and unrecognized for a long period of time." The ERCs are dedicated to the eradication of this ignorance.

Two recent reports from the Congressional Office of Technology Assistance (OTA) support the conclusion that funding of the ERCs ought to be maintained. The OTA report "Preventing Illness and Injury in the Workplace" endorses the graduate training being provided by the ERCs and points out that cutbacks in federal training can be to reduce the number of trained professionals.[3] The OTA report "Reproductive Health Hazards in the Workplace" states "what is known about reproductive health hazards is far outweighed by what is unkown."[4]

A recent report from the Health Resources and Services Administration (HRSA) of the Public Health Service entitled "Education and Training for Health Risk Assessment and Management of Hazardous Waste" also emphasizes the importance of professional training through the ERCs. This report notes that "professional training cannot be instituted in the hazardous waste area without the ERC structure." It calls for more such training.[5]

I realize that in coming before you today to plead the case for continuing support of the ERCs, I do so in difficult times. The pressures of the federal deficit and the dilemma of the Gramm-Rudman-Hollings Act make it necessary for the Congress to make difficult decisions affecting the futures of universities. I can only say that we, in the universities, are fully aware of these difficulties, and we understand fully the need to make sacrifices on many fronts. Thus, we do not ask for any expansion of our present programs. We seek only the maintenance of our presently diminished programs and we ask stability for the future to protect these frail programs against the further chaos of the disorderly phase-downs proposed by this current Administration.

The costs of occupational disease are massive. The cost of training professionals to prevent these diseases is minute. Training is, therefore, cost-effective. Perpetuation of training programs will save this nation millions of dollars and help reduce spiralling health-care costs.

Thus, respectfully, I urge you to support the restoration of 9.9-million dollars to the NIOSH training budget to support the ERCs and other training projects in occupational health and safety.

Thank you. I shall be pleased to answer any questions.

References.

1. Boardman B, Greaves I, Levenstein C, Landrigan PJ: The Pattern of White House Budget Office Decisions in Environmental Health Research: A Statistical Analysis. Report to Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce of the U.S. House of Representatives and to the American Public Health Association, September, 1986.

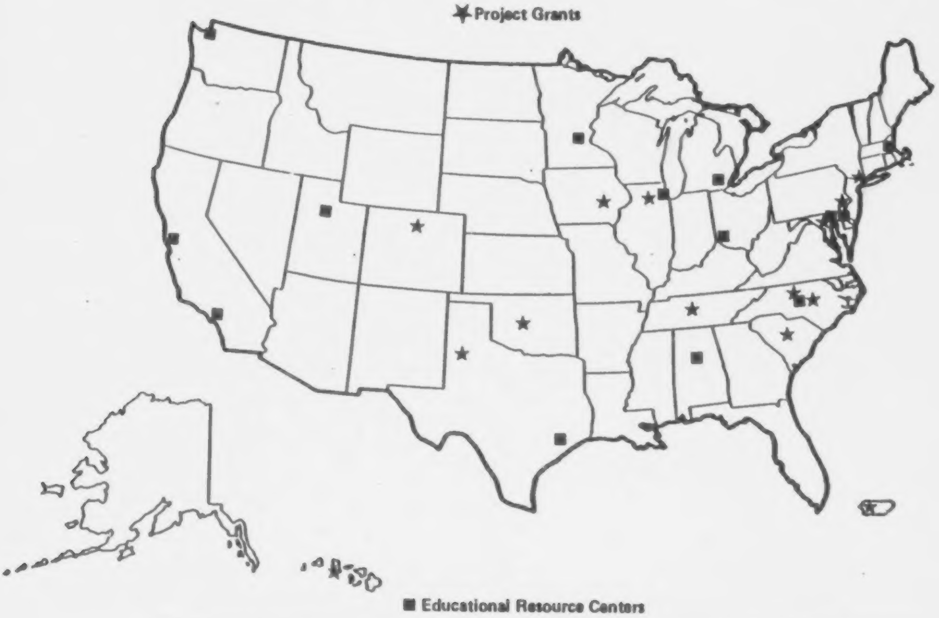
2. Landrigan P, Markowitz SB: Occupational Disease in New York State. Proposal for a Statewide Network of Occupational Disease Diagnosis and Prevention Centers. Report to the New York State Legislature, February 1987.

3. U.S. Congress, Office of Technology Assessment. Peventing Illness and Injury in the Workplace. (OTA-H-256) Washington, D.C., April 1985.

4. U.S. Congress, Office of Technology Assessment. Reproductive Health Hazards in the Workplace. (OTA-BA-266) Washington, D.C., December 1985.

5. U.S. Public Health Service, Health Resources and Sciences Administration. Education and Training for Health Risk Assessment and Managment of Hazardous Waste, Washington, D.C., 1987.

OCCUPATIONAL SAFETY & HEALTH TRAINING GRANTS



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University of California (Berkeley)

University of Southern California

University of Cincinnati

Harvard University

University of Illinois

Johns Hopkins University

University of Michigan

University of Minnesota

Mt. Sinai School of Medicine

University of North Carolina

University of Texas

University of Utah

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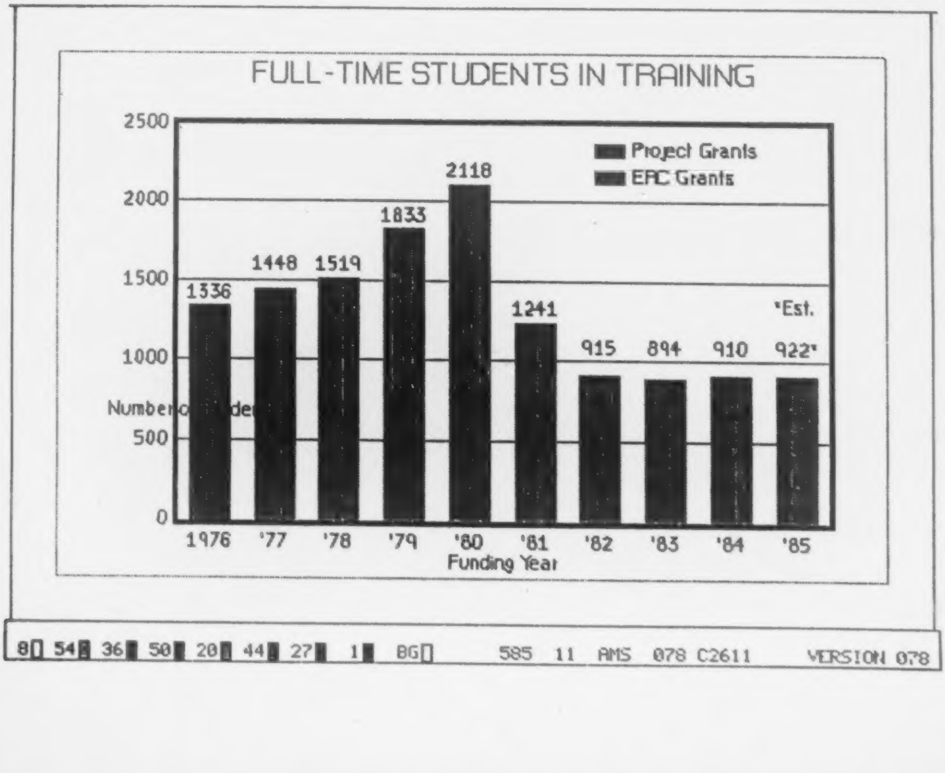

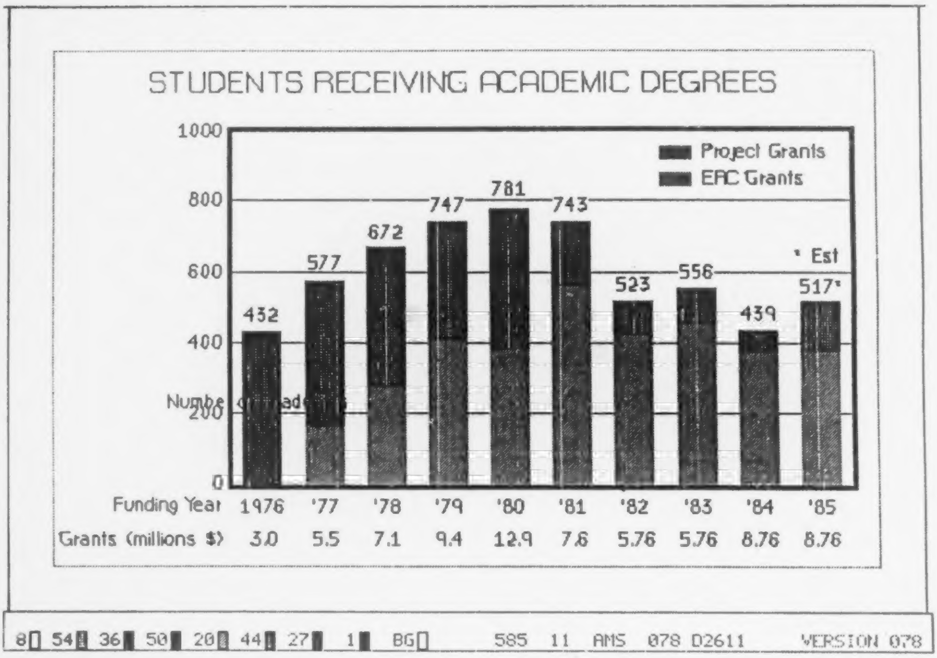
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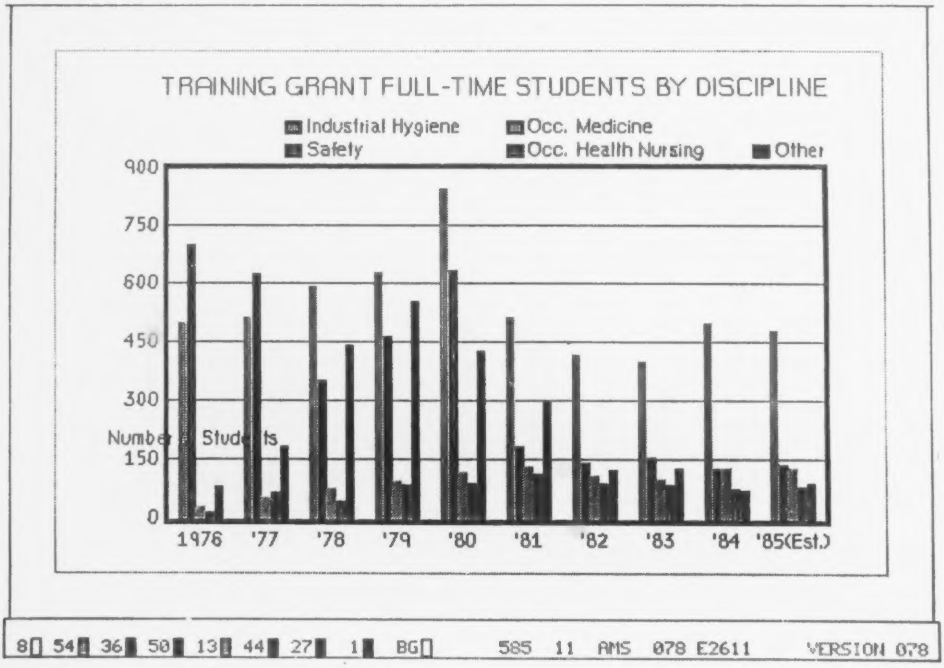
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Occ. Medicine
Safety
Occ. Health Nursing
Other
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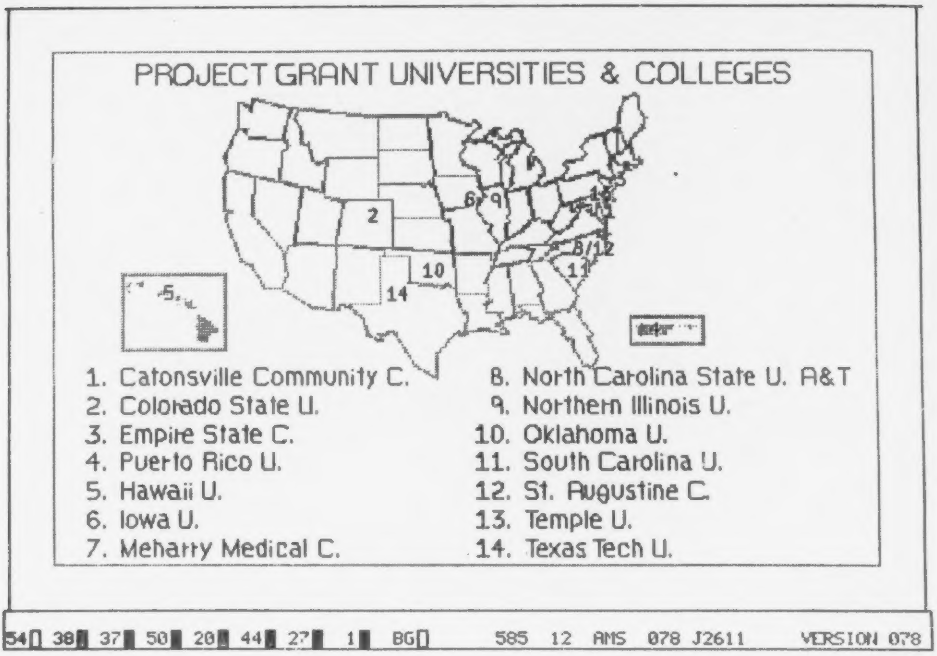

PROJECT GRANT UNIVERSITIES & COLLEGES

1. Catonsville Community C.
2. Colorado State U.
3. Empire State C.
4. Puerto Rico U.
5. Hawaii U.
6. Iowa U.
7. Meharry Medical C.
8. North Carolina State U. A&T
9. Northern Illinois U.
10. Oklahoma U.
11. South Carolina U.
12. St. Augustine C.
13. Temple U.
14. Texas Tech U.

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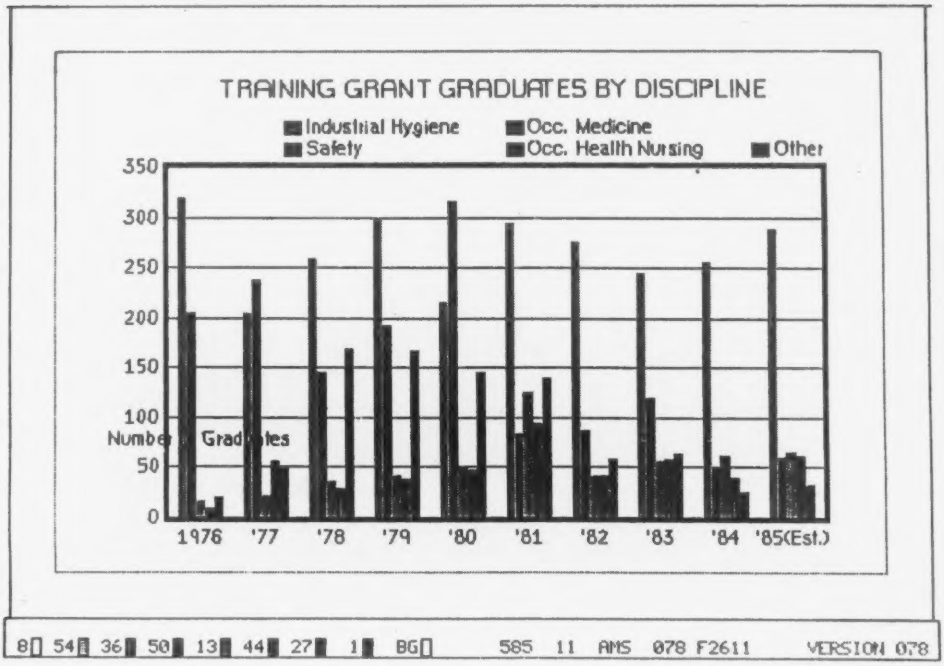

TRAINING GRANT GRADUATES BY DISCIPLINE

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LETTERS FROM T. FORREST FISHER, M.D., PRESIDENT, AMERICAN OCCUPATIONAL MEDICAL ASSOCIATION

December 18, 1986

Philip J. Landrigan, M.D.
Director
New York/New Jersey Educational Resource Center
Mt. Sinai School of Medicine
1 Gustave Levy Place
New York, New York 10029

Dear Dr. Landrigan:

It is a pleasure to send you the enclosed correspondence from the American Occupational Medical Association supporting funding of the Educational Resource Centers.

The members of "The American Occupational Medical Association" want to work with your staff to provide clinical opportunities for your residents, students and trainees.

The demand for occupational safety and health professionals is greater than ever and through cooperative efforts, we can provide the trained professionals to meet the challenge.

Sincerely,

T. Forrest Fisher

T. Forrest Fisher, M.D.
President
American Occupational
Medical Association

May 15, 1986

The Honorable Lowell P. Weicker, Jr.
Chairman, Senate Appropriations Subcommittee
on Departments of Labor, Health & Human
Services, Education
Room 303, Hart Senate Office Building
Washington, D.C. 20510

RE: Public Law 91-596

Dear Senator Weicker:

In 1977 Congress directed NIOSH, under authority of the OSHA Act of 1970 (P.L. 91-596), to establish a network of Educational Resource Centers across the country. A major effort then began to recruit and educate the professional manpower needed to ameliorate these problems. However, in 1981, just as the 14 ERCs were beginning to have a nation-wide impact, the programs were nearly eliminated through drastic federal cuts. Since then, the ERCs have been operating with severely reduced resources, while the needs of the region have continued to grow.

As the President of the American Occupational Medical Association, a non-profit professional association which represents 4,000 physicians practicing occupational medicine in the United States, I request your continued support to re-fund the training budget of CDC/NIOSH at a $9.9 million level in the Labor/HHS Appropriation. This figure includes reductions for the fiscal year 1986 by provisions of the Gramm-Rudman law. It would restore the current level of funding and provide an additional $1.5 million to permit the ERCs to conduct urgently needed research on occupational health and safety problems.

Sincerely,

T. Forrest Fisher, M.D.
President, American Occupational
Medical Association

STATEMENT OF DR. NEAL BARNARD, THE PHYSICIAN'S COMMITTEE FOR RESPONSIBLE MEDICINE

Introduction: As a result of exploitation for research and entertainment as well as a decrease in habitat, the chimpanzee has been listed as Threatened under the Endangered Species Act and is also listed under Appendix 1 of CITIES. Wild chimpanzees have been given some protection from biomedical research because of this legislation Due to a flaw in the regulations under the Endangered Species Act, additional chimpanzees may be obtained for use in medical experiments if they are "captive bred." Chimpanzees, unlike many other species used in experiments do not breed well in captivity. Scientists agree that this is primarily due to the unnatural and anti-social conditions in which they are placed and as a result, are unable acquire appropriate parenting skills. After decades of indifference to the needs of these primates, and as the supply dwindles, biomedical researchers are now looking for methods to increase the supply for use in future medical experiments.

The National Institutes of Health (NIH) decided to implement a "National Chimpanzee Breeding Plan" in late 1985 and awarded the first 10 contracts under the program in 1986. Congress has never authorized the program. Because the Director used funds from his discretionary budget for AIDS research in 1986, no monies have been appropriated for the project. Neither the Congress nor the public has had an opportunity to evaluate the merits of this program. The NIH is expected to renew the contracts for FY 1988, again with no outside review a program which will cost the government over $11 million for its first 4 years of operation. Because of the serious flaws in methodology associated with the program, Congress should not appropriate any funds for FY 1988 to continue the project.

The Problems Associated with the Project:

1. The project is likely to fail.

The data indicate that the existing collection of captive bred chimpanzees is unlikely to reproduce at the rate suggested by NIH because second generation captive chimpanzees are unable to learn normal mothering techniques. NIH has attempted to solve this problem by using chimpanzees who have been taken from the wild to mother the chimpanzee babies or rearing the infants by human technicians. The number of existing wild caught chimpanzees is dwindling and eventually the various laboratories will have only a collection of captive bred females. These chimpanzees may give birth but will be unable to care for their young. The young will therefore be taken from their mothers at a young age perpetuating the cycle of inadequate parenting techniques. The various existing chimpanzee research laboratories have not demonstrated that their second generation chimpanzees will breed and properly care for their young and therefore the breeding plan is doomed to fail.

Furthermore, the agency has failed to appoint any recognized expert on natural chimpanzee behavior to evaluate the project. The same institutions which have caused the anti-social behavior of the chimpanzees are now in charge of this project.

The proposed estimates of the captive bred population which will be available for bio-medical research bear no relation to the breeding records of chimpanzees either in the wild or in captivity. The institutions receiving grants under the program have evidenced an inability to provide a healthy environment for chimpanzees which would promote good parenting skills. Because only the institutions which now have chimpanzees could apply for a grant (because only they had potential breeders) the institutions which have failed to provide an appropriate environment in the past for normal chimpanzee behavior are the very institutions awarded contracts with no stipulation for minimum requirements for the psychological well-being of chimpanzees.

One major concern of the environmental and animal protection community is that once the project is well under way and the second generation fails to breed, the NIH will invariably then turn to Congress and /or the Department of the Interior for permission to import wild chimpanzees to perpetuate the project. After investing millions of dollars into the project, the Congress will be pressured to support an exemption to the Endangered Species Act allowing for the importation of this threatened species.

2. The Project has not been approved by Congress.

The National Chimpanzee Breeding Plan has never been authorized nor has Congress specifically appropriated Federal monies to fund the program. With the contracts already approved by NIH, the project will cost over $11 million in its first 4 years of operation. The project must run for at least twelve years because that is the age of sexual maturity in chimpanzees. Once the project is underway, it is unlikely that any unbiased evaluation will cause a reassessment of the viability of the program. The Congress and the public have been given no opportunity to discuss the serious flaws with the program before tax dollars are needlessly wasted. The project should be denied funding until such a review can occur.

3. The Project has used AIDS funding and is unlikely to benefit the victims of AIDS.

Monies for this project have come from the Director's discretionary fund for combatting the AIDS crisis. Scientists are discovering that the chimpanzee is inappropriate to study the AIDS virus or vaccines. Although chimpanzees can be infected with the AIDS virus they do not develop AIDS and the immune system of chimpanzees is sufficiently different from humans so that tests in one may say nothing about how the other will respond. According to Dr. Robert E. Pollack of Columbia University in an article in The New York Times, animal models of AIDS are no longer necessary because recombinant vaccines can be tested in a bacterium.

Even if chimpanzees were appropriate "models," the breeding program could not produce significant numbers of animals for 10-15 years. Given the urgency of the AIDS problem, an investment in this program over other research efforts is an ineffective use of funds.

Also, given a current collection of 1200 chimpanzees in United States research institutions, some of whom cannot be used for future research because they have been experimentally exposed to various diseases, the bio-medical research community simply cannot produce the assembly-line of chimpanzees suggested necessary by NIH for testing AIDS vaccines. Given the intensive quantity of testing necessary to study the AIDS virus, even the most optimistic estimates on the numbers of available chimpanzees is woefully inadequate to serve as a model for vaccine experiments.

Funds proposed for the project for FY 1988 come from the Division of Research Resources. The proposed funding has still not been analyzed and the proposed uses for the chimpanzees in research have not been adequately justified.

4. Chimpanzees are an inappropriate subject for bio-medical research.

The chimpanzee is the species closest to humans behaviorally and biochemically. The chimpanzee shares close to one hundred percent of its genetic endowment with man. He also shares our feelings of selfawareness, compassion, friendship bonds, sensitivity to pain and suffering, memory and many other attributes. It is this likeness that makes them sought after for bio-medical research. It is also this likeness which raises ethical questions about substituting one individual for another in research. The use of individuals who have such similar behavioral, social and genetic makeup to that of man is unethical, particularly in areas of research in which alternatives exist.

Conclusion: The National Chimpanzee Breeding Plan has not been adequately researched and is likely to fail. NIH has used the AIDS crisis as justification for its existence but it is unlikely to benefit the victims of AIDS. In all likelihood the program will be used as justification in the future to take more endangered animals from the wild. The NIH has not established a proposal that can be supported by objective scientific data and therefore Congress should deny the use of federal monies to fund the project.

STATEMENT OF THEODORE W. VAN ZELST, MINANN, INC.

Mr. Chairman, my name is Theodore W. Van Zelst. I am presenting this testimony as an individual and also as president of Minann, Inc., a foundation which has been actively involved for the past four years on matters related to a disease which is now receiving more attention, Chronic Epstein-Barr Virus Syndrome (CEBV).

Nearly everyone is exposed to the common Epstein-Barr virus, which stays in the body for life. In most people it remains dormant and causes no harm. In others, the virus is active (or reactivated) and chronic illness sometimes results. The severity ranges from fatigue to total disability. Research on this illness has led to the diagnosis of CEBV, a condition that can affect the entire body and often is mistaken for other illnesses.

Typical CEBV symptoms include extreme debilitating fatigue and exhaustion; muscle aches; sore throat; headaches; swollen lymph glands; difficulty in concentrating; fever, dizziness; depression and irritability. Extreme fatigue has been reported to be constant and unrelieved by a high percentage of the patients.

CEBV research studies to date have opened up some new avenues and patients are looking for expansion of the CEBV research and the development of a surveillance network which will help solve many of the problems and answer the questions related to a disease which has these symptoms.

In its report on the Fiscal Year 1987 budget for the Department of Health and Human Services, the Committee on Appropriations requested a report before the Fiscal Year 1988 budget submission clarifying the controversy within the scientific community regarding CEBV and submitting a plan to resolve this controversy through continuing research and public education.

The National Institutes of Allergy and Infectious Diseases (NIAID) has been supporting some extramural investigators doing research on Epstein-Barr virus including research on chronic EBV infections. Intramural research programs are also underway and the studies under Dr. Stephen Straus have evaluated nearly 100 patients with chronic fatiguing syndrome. NIAID has assisted physicians throughout the U.S. in the evaluation of several hundred other patients.

The studies related to Epstein-Barr virus (EBV) have developed many questions, most of them still unanswered. The NIAID has stated that the association of the chronic fatiguing syndrome with EBV is still hypothetical. They have studies which suggest that the EBV virus is not the cause of most chronic fatiguing illnesses. Included are those illnesses which usually do not begin as acute infectious mononucleosis and lack many of the features of that syndrome. Some individuals lack antibodies to EBV and therefore have never been infected with the virus, yet have the same syndrome. Some of the individuals who possess antibodies to EBV proteins in amounts and patterns suggestive of recent or active EBV infections are totally without clinical symptoms. Additional research is essential to a deeper knowledge of what is being called CEBV.

Acute infectious mononucleosis, another term frequently associated with Chronic Epstein-Barr Virus, is a syndrome (a set of symptoms). The NIAID said this can result from several different causes. It has been shown, however, that EBV is the most common cause of this syndrome, accounting for about 90% of all typical cases. They state that scientists can prove that a given case of acute infectious mononucleosis was caused by EBV by determining over time the levels in patients of different classes of antibodies to different proteins of EBV. However, tests for antibodies to EBV proteins have not been highly reproduceable both within and between laboratories.

Researchers and practicing physicians say that diagnosis of the Chronic Epstein-Barr Virus Syndrome is very difficult because all of the various symptoms can be found with other diseases as well. At the Centers for Disease Control, studies by Dr. Gary Holmes and Dr. Jonathan Kaplan showed that antibody titers to EBV were not helpful in determining which patients had the syndrome. Thus, in order to diagnose the syndrome, a specific set of clinical criteria must be used which rules out other diseases. The CDC with the assistance of other investigators active in this field has started developing a clinical definition of chronic mononucleosis-like syndrome (CMLS) which they propose to use in surveillance studies of the prevalence of the chronic form of mononucleosis which has generally been referred to as Chronic Epstein-Barr Virus Syndrome.

The CDC has stated that although there is a perception that many patients have this syndrome, that the true public health burden is not now known. They believe that by using a clinical definition which excludes other diseases, they will be able to obtain data on the number of true cases. They expect the clinical definition to be stringent and therefore the estimated number of cases will probably be low and only of the most severely afflicted patients. They are in process of organizing a surveillance network study. The CDC expects that patients found through their epidemiological studies will allow them to evaluate possible risk factors associated with this syndrome.

In November, 1986 a two-day CEBV conference was held in Austin, Texas. The meeting was well attended by doctors from all parts of the U.S. who are working on CEBV research. The conference, which had no institutional support, drew participants who had the opportunity of discussing their studies and to meet face to face to exchange ideas on the CEBV syndrome. The conference was an indication of the dedicated interest of many CEBV researchers in learning more about this perplexing illness.

At the Austin conference, Dr. Paul Cheney, who studied many of the patients in the 1985-86 Incline Village (Lake Tahoe) outbreak, said that the recognition gap is closing between physicians and the patients who believe they have this disease. In the study of the Incline Village patients, more than 8 universities and governmental departments were involved in analyzing the cause and effects. It was noted that most of those patients became ill in 1985, but there has been no continuing trend. Neurological problems were found in a large number of patients. Researchers noted balance problems as well. Dr. Cheney commented that CEBV may be a cyclic disease. His studies showed that 20% of his patients feel that they have totally recovered; another 50% feel improved; whereas 20-30% remain very ill or have cyclic recurrences.

Some CEBV researchers believe the EBV serology at present is useless. In the Incline Village studies they found the EBV serology failed to discriminate between patients. Their data appears to show on 11% clearly fell into the CEBV category. What afflicted the others?

A manuscript on the study of the Incline Village epidemic has been completed. It is expected to report some further serious findings. Evidence will be presented that this illness can produce various abnormalities of the immune system and of the central nervous system, and that it is probably somewhat contagious.

A CDC representative at the Austin conference stated that there is a syndrome and that there is something out there affecting people. The disease needs a clinical description and/or a test to define it.

In 1986 the CDC started a trial telephone survey to physicians randomly selected from phone books of cities as well as rural areas. Questions were asked of physicians about whether they felt the incidence of CEBV was going up or down, and whether the physician would participate in the CDC surveillance networking. The exploratory survey may give an indication of the number of physicians who recognize the CEBV syndrome and believe they have patients who suffer from this syndrome. CDC also expects that a survey program could identify a network of patients and help indicate how much of this disease exists.

One research project was to survey the frequency of the CEBV syndrome in general medical practice. Dr. Anthony Komaroff, Chief, General Medicine, Brigham & Women's Hospital, Harvard Medical School, directed this research project. Past published studies could not deal with the question of how common (and, hence, how important) this problem might be. The study led to a striking result: 21% of young adults seeking medical care for any reason stated, if they were asked, that they had been suffering from a syndrome consistent with the CEBV syndrome, but had been told there was nothing wrong. Results of this study are expected to be published in the Journal of the American Medical Association (JAMA) in May, 1987. This is one of the most widely read medical journal in the world.

Other research investigated the similarities between chronic mononucleosis and fibrositis. There are leads which may show that these may be the same or related illnesses. An article on this study is expected to appear within the next two months in the Journal of Arthritis and Rheumatism.

Dr. James Jones, Staff Physician, National Jewish Center for Immunology and Respiratory Medicine, Denver, is working on some studies of the central nervous system, and is receiving cooperation from the National Institute of Mental Health.

Another project at the National Jewish Center for Immunology was to develop the technique for identification of the lymphoid cell type, for instance, the B lymphocyte or T lymphocyte (or T-cell subset) which contains the Epstein-Barr virus in certain clinical situations. This technique was applied to lymphomas (tumors) which developed in three patients with a severe form of CEBV. These patients were different from the usual CEBV patient in that their antibodies were extraordinarily high (anti-VCA is greater than 10,000) and they have pneumonia, hemotological problems and gamma globulin problems. Studies showed that the EBV gene was present in the T-cell tumors in these patients. T-cell tumors have never been described in association with EBV infection previously. These observations are being submitted to a journal for publication.

One medical group, Dr. Irena Brus and Dr. W. Reeves, is studying the possible relationship of CEBV with collagen vascular diseases. Others are studying the relationship to allergies.

Preliminary research is underway with a technique called DNA in-situ cytohybridization by Dr. Anthony Komaroff collaborating with Dr. Robert Singer. This technique allows the finding of the EBV virus (or other viruses) in tissues taken from patients. It is believe this technique could be a direct and convincing way of determining whether EBV or other viruses are actually producing this illness. This may allow for a more precise diagnosis.

Recently Dr. Robert Gallo at the National Cancer Institute (NCI) and collaborators reported the isolation of a new human herpesvirus, human B-lymphotropic virus (HBLV). There is believed to be a relationship to the CEBV syndrome, but this is uncertain at present and is expected to be studied jointly by NCI and NIAID investigators.

One researcher stated that the identity of the HBLV agent is still unknown as is the general spectrum of illness that it may be associated with in the population at large. Research underway may indicate that HBLV is an important cause of the illness now known as CEBV. This could lead to testing of the drugs like acyclovir or desiclovir to 'kill' HBLV in the test tube in the laboratory. Hopefully, full testing of these medicines could follow.

Other CEBV research is continuing at universities, medical centers and in private practice. We have not attempted to list all of the programs, but only to indicate some of the work which is underway.

This testimony introduces acronyms: CMLS, Chronic Mononusleosis-like Syndrome; HBLV, human B-lymphotropic virus. The patients who suffer from the CEBV syndrome are not concerned about what the disease is called, but are pleading for continuing research which will lead to a better diagnostic technique, treatment and an eventual cure.

There is still a serious question of which virus is actually involved. The following comments by CEBV researchers indicate a need for continuing research:

Dr. Anthony Komaroff: "I have no doubt that what we're dealing with is a very real and important syndrome. It is an open question what virus is involved."

Drs. Gertrude and Werner Henle, researchers at Children's Hospital of Philadelphia said that while they believe they have some people suffering a chronic fatigue syndrome, much research must be done before the cause will be clear.

Dr. Gary Holmes, Infectious Disease Specialist, Centers for Disease Control, said "It was possible the Epstein-Barr virus was to blame for the chronic fatigue people have been experiencing, but it is no better candidate than a couple of other viruses that are known, and there is a good chance it's an undiscovered virus."

The disease which we will continue to call CEBV for purposes of continuity, is receiving continuing and expanded media attention. 'The Donohue Show' and 'Good Morning America' covered the disease on recent national TV programs. New Republic, U.S. Magazine, American Health and the San Francisco Chronicle were some of the publications which had stories on CEBV in the past few weeks. Stories are in preparation for upcoming release in other national publications. Each coverage on radio, on television, and in news magazines or daily newspapers brings in another deluge of requests for information, mostly from people who are trying to identify a disease from the symptoms that afflict them--symptoms which have puzzled their own physicians.

The National CEBV Syndrome Association in Oregon has processed more than 15,000 inquiries in the past month (April 1987). They have approximately 4500 members and over 100 self help support organizations throughout the United States serving many people afflicted with the symptoms that are indicated as being CEBV.

Doctors familiar with CEBV report that many physicians are still disbelievers and disclaim that the disease (CEBV Syndrome) even exists. Publication of the results of research on this disease will help to acquaint more physicians with this syndrome.

The medical studies related to the perplexing illness, CEBV, have attracted a substantial number of researchers who are conducting studies with relatively little public funding. Many have worked on this research because of a personal interest developed through their patient contacts. Many of them have contributed their own time and resources in an attempt to contribute to the solution of this complex medical syndrome. Many of these studies are of a start-up nature to prove or disprove a new theory, or to use data accumulated from patient visits, or to utilize laboratory data in research studies.

Some hospital research organizations have supported CEBV studies. Other funding for these specialized studies, for laboratory tests, support personnel and expenses has come from individuals and foundations.

The process of applying for government funds normally involves a peer review committee and a considerable length of time for acceptance (or rejection). We would like to suggest that the National Institutes of Allergy and Infectious Diseases (NIAID) make funding available for Mini-Research Grants on Chronic Epstein-

Barr Virus Syndrome (CEBV) to qualified researchers who have a new lead or direction to pursue but which needs to be evaluated on an informal or short term basis before the study has its full scale or potential known.

An objective of the Mini-Research Grant program would be to make funds available for specified CEBV studies with the review procedure by persons familiar with the CEBV syndrome in a shorter processing period.

NIAID could provide a basic fund of up to $500,000 to make research grants of under $25,000 to doctors and medical researchers who are working in new exploratory areas in the study of the CEBV syndrome (and related viruses), or who have emergency needs for studies related to this disease (ie, an epidemic or cluster out-break). These grants could be for short term support of graduate students engaged in CEBV research; for support staff (nurses or technicians) who reserve time for patient studies; for testing and analysis of laboratory data; for medical conferences related to this syndrome.

By its interest in this disease which affects to many people, this Committee has provided many CEBV patients and their families with some hope. The support of this Committee has been of utmost importance in advancing research on this illness.

We urge this Committee to recommend:

1) That the National Institute of Allergy and Infectious Diseases continue to conduct and sponsor research on the Chronic Epstein-Barr Virus Syndrome (including related viruses) in the search for a diagnostic technique, means of treatment and an eventual cure.

2) That a Mini-Grant Program be established (or activated) to provide funds for studies of the Chronic Epstein-Barr Virus Syndrome to qualified researchers who are working on exploratory studies related to this disease or who have emergency needs (ie, study of an epidemic or outbreak).

3) That the Centers for Disease Control be financially supported in the development and implementation of a CEBV surveillance network to serve as a clearinghouse for medical information to assist physicians, researchers and patients.

Progress is being made in the understanding of this disease. Many more physicians have become aware of this CEBV Syndrome. Research studies are well underway on the chronic form of this illness are leading to new discoveries which may be of vital importance concerning known and as yet unknown viruses.

The actions of this Committee have had a significant impact on better understanding of this illness. On behalf of the dedicated researchers, the many patients and their families, we ask that the Committee continue in its efforts so that research will lead to answers about this debilitating syndrome which affects the lives of so many Americans.

STATEMENT OF DALE P. DIRKS, TREASURER, AMERICANS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT

Mr. Chairman and members of the subcommittee, thank you for the opportunity to discuss funding priorities in the health care field on behalf of the Americans for Substance Abuse Prevention and Treatment.

This is the second time our organization has appeared before your subcommittee. ASAPT is a very young organization, but we boast of a membership of over 20,000.

The Anti-Drug Abuse Act of 1986, enacted by Congress, enhanced many of the federal programs already established to study, and combat mental disorders and alcohol and drug abuse. Also, established were several new key mechanisms for funding treatment and prevention activities and coordination.

The Americans for Substance Abuse Prevention and Treatment believes this major thrust is a magnificent display of Congress' recognition that drugs and alcohol continue to plague families and individuals in America. Clearly, the destructive effects of chemical dependencies and abuse of alcohol are being recognized more than ever.

That is most encouraging news. Other encouraging news from the community is that there is hope for individuals and families affected by substance abuse. More Americans are seeking treatment now than ever before. Prevention, intervention, education and treatment techniques are more advanced and successful as well. So, a person who is affected by alcohol or drug abuse is now more likely, through counseling, group therapy and other treatment techniques, to gain or regain a normal existence and family life.

Because of this, we urge your subcommittee to sustain this critical focus of support and attention by continuing adequate funding for the traditional mechanisms and new programs established to combat the sometimes frustrating problems associated with substance abuse.

We view the Administration's proposed fiscal year 1988 budget for ADAMHA as inadequate. In recognition of the deficit reduction commitment, while keeping in mind the need to continue a strong commitment to research, we recommend the committee adopt the FY'88 funding proposals of the Mental Health Liaison Group.

Mr. Chairman, I would like to discuss the many areas of clinically related research which the Americans for Substance Abuse Prevention and Treatment feel need to be pursued.

- Patient Placement - Peer reviewers for Medicare and employers daily decide that substantial numbers of chemically dependent or psychiatrically ill individuals cannot be admitted to certain programs because they are not "sick enough". Continued emphasis must be placed on research leading to the development of standardized patient placement systems to match chemically dependent or psychiatrically ill individuals with the appropriate level of care corresponding to the stage or severity of the disease diagnosed. People who are in the middle or late stages of a disease may need hospital care, while those in the early stages may only require outpatient treatment.

- Treatment Outcome - Research is particularly scarce in the areas of adolescent treatment outcomes and treatment of cocaine abusers. Recently, adolescent drug addiction and chemical dependency patients have swamped treatment and rehabilitation facilities. Many of our nation's young people are leading tragic lives because of chemical dependencies.

- **Barriers To Treatment** - Research is needed on why people with chemical dependency problems or psychiatric problems go without help for so long before receiving treatment, and the mechanisms for overcoming those barriers. For example, 85 percent of this nation's 14.7 million alcoholics and problem drinkers do not receive formal help for their disease. Of the 10-12 million children suffering from mental disorders, only 500,000 are receiving any kind of treatment through the mental health care system. The problems of alcohol and chemical dependencies, and mental disorders are still very much stigmatized by society and even the supposedly informed medical community. We encourage research efforts to eliminate these restrictions.

- **Health Hazards of the In-Drugs** - Research is needed on some of the health hazards of such "in" drugs of adolescents as clover cigarettes, liquid paper, designer drugs, and hazardous substances that are inhaled or sniffed.

We recommend NIAAA and NIDA collaborate with the Department of Transportation on developing new tests for screening drunk drivers. Once tested, drunk drivers diagnosed as chemically dependent could be referred to legitimate treatment programs, rather than "education" classes.

BLOCK GRANTS

The Administration's request for $495 million for alcohol, drug abuse and mental health block grants is at the same level as FY'87, but in real dollars it is at least a 10 percent cut from the FY'86 services. To maintain existing services and provide funds for programs for mentally disturbed children and chemically dependent women, authorized in the ADM Block Grant Amendments, we urge adoption of a funding level of $650 million. While federal support for chemical dependency and community mental health services has declined during the past few years, the demand for services continues to increase. Thus, we fully support the addition of funding for state supplemental alcohol and drug treatment grants at a level of $195 million.

OFFICE OF SUBSTANCE ABUSE PREVENTION

The Office of Substance Abuse Prevention was established under the Anti-Drug Abuse Act of 1986. Located within ADAMHA's Office of the Administrator, OSAP functions as the focal point for our nation's alcohol and drug abuse prevention activities. A great deal of work has been conducted in developing and organizing the five divisions within OSAP. For example, the NIDA and NIAAA Clearinghouses have been combined into one new "Division of Information Resources'. The Division of Community Assistance has arranged for grants for workshops and other initiatives that focus on youth, families, and special populations, as well as providing technical assistance to local communities and national groups. The Office of the Director is in place, and a major responsibility of that office will be coordinating activities with national corporations and foundations.

Of the amount appropriated for OSAP, $20 million is specifically mandated for demonstration projects for high-risk youth. ASAPT believes that these projects are vitally important and strongly supports OSAP's plans for early intervention initiatives and other activities aimed at high-risk youth.

While funding for these demonstrations should be maintained, monies for demonstrations to focus on other drug and alcohol abusing populations are needed as well. For this reason, the ASAPT recommends a substantial increase for demonstration projects in FY'88.

Further, since the goals and objectives of the Office of Substance Abuse Prevention require highly labor-intensive activities, the ASAPT recommends a $2 million increase in direct operations. While OSAP currently has 50 FTEs, we believe that at least 65 FTEs are needed.

Finally, and most importantly, the ASAPT is concerned with attempts by the Administration to administratively allocate funds appropriated for FY'87 over FY'88 as well. The impact of this shortsighted policy would be to halve OSAP's budget and the funding available to prevent drug abuse and alcohol in this country. We recommend a rejection of this budget policy (as we have in the research domain) and an alternative appropriation for OSAP of $65 million.

NATIONAL DATA GATHERING

With the development of the block grant system, states are no longer required to uniformly report data to NIAAA and NIDA. This lack of a comprehensive national data base, including all public and private programs, makes it difficult to know how many people are being treated, what their alcohol and drug problems are, where they are being treated and the like. We urge restoration of the National Drug Abuse and Alcoholism Treatment Utilization Survey, NIDA's Client Oriented Data Acquisition Process and other national data gathering studies.

The Americans for Substance Abuse Prevention and Treatment are aware of the current situation as it relates to payment for alcohol and drug abuse related to Medicare treatment under the DRG system. Without going into great detail, I would merely like to encourage Congress to closely follow the implementation of alcohol related DRGs and insure that adequate consideration is given to those Medicare beneficiaries in the nation who are chemically dependent or substance abusers.

To help offset the deficit, we urge that additional revenues be raised by boosting the federal excise tax on cigarettes to 32 cents per pack and by raising the excise tax on beer and wine, as has been done with distilled spirits. Cigarette smoking and the abuse of alcohol are major causes of illness and premature death in the United States. A tenth of the drinking population consumes half of the alcoholic beverages sold. We believe those who smoke and drink excessively should help pay for the increased cost that they generate for the medical system.

Mr. Chairman, thank you for the opportunity to present our views. We very much look forward to a continued good relationship.

RECOMMENDATIONS FOR FISCAL YEAR 1988:

A. Appropriate $475 million for the National Institute on Mental Health (NIMH), $209 million for the National Institute on Drug Abuse (NIDA), and $105 million for the National Institute on Alcohol Abuse and Alcoholism (NIAAA), in accordance with the recommendations of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Appropriations Coalition.

B. Provide $65 million for the Office of Substance Abuse Prevention, established by the Anti-Drug Abuse Act of 1986. The OSAP functions as the focal point for our nation's alcohol and drug abuse prevention activities.

C. Appropriate $650 million for the Alcohol, Drug Abuse and Mental Health (ADMS) block grant. Provide $195 million for the expansion of alcohol and drug abuse treatment capacity in the publicly funded service sector.

D. Restoration of resources for adequate funding of alcohol and drug abuse data collection and storage and continued funding for support of the National Clearinghouse for Alcohol Information.

E. Increase the federal excise tax on beer and wine to a rate equal to that of hard liquor, and increase the federal excise tax on cigarettes to 32 cents per pack, the level it would be if indexed for inflation since 1951.

F. Utilize additional research funds to develop research projects on patient placement, treatment outcome, barriers to treatment, DUI screening tests, treatment needs formulas, prevalence surveys, health hazards of "in" drugs, and technical assistance.

STATEMENT OF DAVID J. MACTAS, PRESIDENT, THERAPEUTIC COMMUNITIES OF AMERICA AND MARATHON HOUSE, INC.

My name is David Mactas. I am grateful for the opportunity to present this testimony before the Subcommittee.

I am President of Marathon House, Inc. Celebrating its 20th anniversary in 1987, it is the oldest and largest non-profit agency of its kind in New England. In addition, I am President of Therapeutic Communities of America (TCA).

Founded in 1975, TCA has evolved into the principal association of non-profit residential drug free programs in the United States, representing some 300 agencies. The Therapeutic Community has long been associated with treatment of the hard core drug abuser. The vast majority of our clients are cocaine and opiate abusers who, by virtue of scant resources, rely on government subsidy to gain access to treatment.

Our programs service approximately 35,000 people per year. The average daily cost of residential care is $42. When viewed against the staggering costs to society of drug abuse and associated criminal activities, cost effectiveness must be seen as significant.

To many of us in "the trenches," passage of the Anti Drug Abuse Act of 1986 was testimony to affirmation of the efforts of treatment professionals toward reducing demand and enhancing the quality of life throughout our nation. That the Congress acknowledged that enforcement without access to treatment was imprudent, served to fuel our enthusiasm - an end to the era of lip service.

Tragically, after review of The President's FY'88 budget request, his "War on Drugs" appears barely a spat.

Perhaps "Seduced and Abandoned" is the more apt moniker for the Administration's pursuits in this regard.

Given the leadership and composition of the Subcommittee, it is, clearly, unnecessary to present evidence of the growing problem of chemical dependence in our society. The litany of incidence and prevalence studies reflect both pervasiveness and severity. The ability of the treatment network to respond to increasing demand continues to be encumbered by overcrowded facilities and interminable waiting lists. Addicts do not fare well on waiting lists. In one ten day period at Marathon House, 14 of those addicts on our waiting list who were called for admission could not be located. They had sought out clinical intervention and were turned away. Attempts to refer them elsewhere at first contact, were futile. The problem is system-wide. As before, we need the help of the Congress.

The President has recommended that $495 million be appropriated in FY'88, under the ADM Block Grant. When adjusted for inflation, this would represent an effective reduction of over 47% in federal support for such services since FY'80. I urge you to consider an appropriation of $650 million in order to address the intent of the Omnibus Drug Bill.

Moreover, while The President proposes no re-authorization, I recommend that those dollars dedicated to the expansion of treatment capacity ($163 million in FY'87) be re-authorized at a level of $195 million. Needless to say, The President's strategy for spreading the FY'87 appropriation over two years is seen as irresponsible and counter to the intent of the Congress.

Again, the same fate is proposed for the newly

established Office of Substance Abuse Prevention which would have its budget cleaved in half. Of the five divisions created under the aegis of OSAP, it is Demonstration Projects which would suffer the most dramatic diminution. From a current level of $20 million, The President proposes a limit of $6.5 million.

These projects, directed at high risk youth, will produce findings and allow for replication of intervention and prevention models nation wide. It is proposed herein that the $20 million allocation for such grants be increased to $38 million.

Overall, it is felt that the OSAP budget, presently $41.5 million, be raised to $65 million vs. the $11.2 million figure presented by Mr. Reagan. However, regardless of disposition, it is essential that The President's notion of extending the FY'87 dollars over two years be rejected.

Of particular concern to the network of Therapeutic Communities is support for research initiatives. Historic inadequate funding for treatment itself has created a paucity, within the treatment community, of research efforts. Accordingly, we look to the Federal Government for resources dedicated specifically to such activities.

Those cuts in research funding proposed by The President for the Institutes are unacceptable. It is recommended that you consider levels of $330 million, $183 million and $89.5 million for NIMH, NIDA and NIAAA respectively. This set of suggestions contemplataes significant activity in AIDS research which must correspond to the eminence of this new and devastating scourge.

We are encouraged that The Administration proposed an

increase for The National Institute of Mental Health Services Demonstration Program. The emphasis is on the unique problems of individuals with severe mental illness for whom integration into the community is seriously impaired. Enhancement of the community support system is a pre-requisite for such integration, and a vital component in a strategy to prevent homelessness. New demonstration projects addressing this community support element would not be funded under Mr. Reagan's plan. Consequently, a $24 million figure is proposed herein to insure adequacy of funding.

All appropriations proposed by Mr. Reagan under the ADAMHA umbrella are seen as inadequate. I have highlighted those which constitute the most direct and serious threat to our capacity to respond to an overwhelming crisis. It is my privilege to represent, not only thousands of dedicated professionals, but legions of the formerly addicted who have courageously and tirelessly reclaimed their spirits and ultimately, their place as productive, drug-free, self-sufficient citizens.

Treatment does work. The process of rehabilitation is laborious and often painful. While there is great drama and exhiliration, there is little fanfare or publicity. However, in this "business," excellence is its own reward. Uncompetitive salaries and anonymity are offset by the gratification of collaborating with our clients toward clinical success. Unfortunately, such abstract reinforcement cannot sustain this nation's treatment impetus. We need your help.

Access and Intervention are, indeed, essential components in a responsive human service system. So, too, are they elements of humane government. The present

testimony is offered via access granted by the Subcommittee. For that, I am most grateful.

Treatment professionals, clients, and society as a whole cry out for your intervention. Mixed messages, hypocrisy and "one-shot deals" serve to exacerbate the present drug abuse dilemma. Erosion of a generation of youth, the emergence of AIDS, and drug related crime have created a climate of urgency. The Anti Drug Abuse Act of 1986 offered promise. As a result of The President's present posture, it is pretense which is perceived by a concerned public.

We all look to the Congress to demonstrate that its stated commitment was not a function of an election year, but the voice of a compassionate and responsive government.

STATEMENT OF THE COUNCIL OF ENERGY RESOURCE TRIBES

The 43 federally recognized tribes that compose the Council of Energy Resource Tribes are very grateful for this opportunity to appear on the record in support of continued, and full appropriations for the Administration for Native Americans. The CERT tribes are firmly convinced that this agency provides, in its Social and Economic Development Strategies program, the most innnovative and flexible of all federal Indian programs, and the one program among all the federal Indian programs that is the most responsive to Tribal needs, goals, and opportunities. The SEDS program is truly responsive to the national policy of tribal self-determination, as set forth in the Indian Self-Determination Act, P.L. 93-638.

A few examples from the CERT experience should serve to illustrate this point, and demonstrate not only the importance of, but also the returns on, the nation's investment in this important agency's programs.

A few years ago, the bank failed that for more than sixty years had served the Blackfeet Tribe. This bank failure left the tribal community, and the surrounding non-Indian community as well, without commercial banking services less than sixty miles away. The tribe requested an examination of possible, alternative banking services and its staff at CERT, with assistance made possible by ANA, conducted this examination and prepared an application in the name of the Blackfeet Tribe for the Comptroller of the Currency to charter the Blackfeet National Bank. Preliminary approval of that charter has been received; the necessary capital has been raised; and the tribe expects to open the doors for business of the Blackfeet National Bank in the summer of 1987. This enterprise will provide critically needed financial services not only to the tribe, but to the surrounding non-Indian community as well; will provide a modest return to the tribe; will provide employment for both tribal and non-Indian residents of the area; and, more importantly, will contribute significantly to integrating the tribal economy with that of the local region.

When the 99th Congress authorized another CERT tribe to finance and construct a 36.5 MW hydroelectric power plant, the tribe required some intermediary assistance in selecting a financial partner and legal counsel, in addition to technical assistance in negotiating contracts with the Corps of Engineers and the Department of Energy's Southwest Area Power Administration. The tribe's staff at CERT was able to provide this short-term assistance as a result of the flexibility of ANA's programs, and the tribe is now working with one of the nation's premier investment banking houses, a reputable bond counsel, and a highly qualified design and construction firm on a project that will be financed in the private sector for more than $100 million.

This project points up another of the tremendous advantages that ANA's programs offer, and that is the possibility of leveraging modest amounts of federal assistance into substantial private sector investments in developing tribal economies. One CERT tribe, with a modest level of assistance from ANA's SEDS program to identify and evaluate alternative economic activities that would provide a reasonable return and also alleviate chronic unemployment problems within the tribe, is now negotiating with possible joint venture partners for the establishment of a poultry enterprise that will produce some 800,000 birds per week. This venture, which will require more than $20 million to capitalize, is expected to pay itself out in less than seven years.

Other projects which CERT tribes are working on as a result of rather modest levels of assistance provided by ANA include establishment of a gasoline and bulk fuels sales enterprise on a reservation; development of a chemical plant on a reservation, utilizing the tribe's own natural gas production as a feedstock, thus providing a stable market in what has become a disturbingly volatile industry and capturing some of the value-added of the tribe's raw materials before they are exported for sale; financing the acquistion of a small sawmill that will provide a steady market for some 12 million board feet of another tribe's timber, create jobs in the woods for dozens of tribal members, and also capture some of the value-added of the tribe's resources before exporting them for market; and yet another CERT tribe, with ANA assistance, has created a Community Development Corporation, is negotiating for a leveraged buy-out of an existing food supplier, and contemplating eventually contracting for the food services requirements of the more than five BIA-run schools in the immediate area.

All of these ANA-assisted projects reflect the importance of the flexibility of ANA's program to be responsive to the particular needs, goals, and objectives of the tribes themselves. There is no federal Indian poultry assistance program; sawmill acquisition program; petrochemical plant program; or food services supply program. Each of these projects represents a unique opportunity for the respective tribes to address peculiar needs, take advantage of unique marketing situations, and to tailor limited federal assistance to address peculiar circumstances, and then to leverage that limited assistance into substantial economic activity.

Another great advantage offered by ANA's SEDS program as well as its Training and Technical Assistance program is that tribes are able to put to very fruitful use limited amounts of assistance from this agency to improve the quality of services they provide to their members and other residents and visitors; to increase the efficiencies of their governmental operations; and even to devise schemes for generating their own revenues to provide these services, thus reducing their dependence on federal assistance for these purposes. In this area, CERT tribes have utilized ANA assistance to design and implement taxation systems that have withstood court challenges; to design and implement merit system personnel practices; to integrate and automate tribal fiscal and accounting systems; and to coordinate tribal government departments and agencies, in some cases to an extent that the federal government itself has difficulty achieving, even on the same reservation.

For these reasons, and as the above examples so vividly demonstrate, the 43 federally recognized tribes that comprise the Council of Energy Resource Tribes, urge in the strongest possible terms that this Committee recognize the unique attributes of this important agency, understand the tremendous contributions which this agency has made to developing diversified and stable tribal economies, and appreciate the improvements in the quality of governmental services which are available to Indians and non-Indians alike as a result of this agency's assistance programs.

Accordingly, the Council of Energy Resource Tribes respectfully requests that this Committee give the most favorable consideration to continued and full appropriations for the continued operations of the Administration for Native Americans in Fiscal Year 1988.

Thank you very much for your consideration.

STATEMENT OF JOAN R. MCFADDEN, PH.D., EXECUTIVE DIRECTOR, AMERICAN HOME ECONOMICS ASSOCIATION

Mr. Chairman and members of the Subcommittee, my name is Joan R. McFadden, and I am Executive Director of the American Home Economics Association which represents over 25,000 members who are concerned about home economics programs in the public schools.

The Administration's proposed budget for fiscal year 1988 would terminate federal funding for Vocational Education including line item funding for the Consumer and Homemaking Education program. I am here to explain to you the role of the federal dollar in support of these programs and to give examples of Consumer and Homemaking Education programs across the country.

Consumer and Homemaking Education programs are a unique facet of Vocational Education. These programs prepare students, both males and females, with basic life skills.

Consumer and Homemaking Education has its roots in what you may know as "home economics." The home economics profession had its beginning in the early 1900's, and since the passage of the

Smith-Hughes Act of 1917, home economics has been partially supported by Federal dollars. Home economics has continued to direct its attention to improving the quality of life for families and individuals.

Just as the family and the needs of society have changed since the 1900's, home economics as a profession has changed its focus to meet the needs of families and individuals. Today, as never before there are many issues facing our families, and consequently, never before have the needs of our Consumer and Homemaking Education programs been so persuasive.

One needs only to look at a few societal facts to see the complex problems facing individuals and families. Let me share a few of those facts with you.

First, the number of women in the work force will soon roughly equal that of men. Already, nearly 70 percent of all women with children under 18 years of age are working outside the home. Surely, one of the largest shifts in American society in this decade.

Second, single heads of households account for 25% of all family units.

Third, single parent families have increased dramatically, with one in every four children living with only one parent in 1984.

Fourth, the teen-age pregnancy rate in the United States is the world's highest in a developed country.

Fifth, drug abuse is a major problem in high schools throughout the country. Alcohol and drunk driving is increasing in the under twenty-one age group.

The dollars you have appropriated for the line item for Consumer and Homemaking Education for this year have gone to programs across the nation which help individuals and families deal with these complicated issues of the eighties. These programs provide the information and skills to help young males and females evaluate the alternatives available to them.

The role of the Federal dollar is very important to these

Vocational Consumer and Homemaking Education programs. Without a Federal presence, the resources that support the opportunity to develop new Consumer and Homemaking Education programs would be jeopardized if not totally eliminated and the constituency they serve would be without the programs they need to develop skills to improve their individual and family life. Imagine a society where young people do not care about healthy bodies and minds, or about being strong and imaginative. Imagine families where there is poor communication and/or management of resources. Imagine babies being born to mothers not yet independent enough to take care of themselves, and fathers not yet mature enough to realize that they have an obligation to the newborn. These concerns, some of which already are reality in staggering proportions in America, are among those currently being addressed by Consumer and Homemaking Education.

The Federal dollars that you appropriated for Consumer and Homemaking Education for this year have gone directly to support the development, initiation or revision of programs in each of your states that provide high school students -- both male and female and members of the community with information for managing family economics and consumer behavior. These programs deal with:

- combining work and family responsibilities,
- improving responses to crises (including avoiding family violence and child abuse),
- strengthening parenting skills,
- assisting handicapped and aged family members,
- improving nutrition,
- conserving limited resources,
- training the handicapped to be self sufficient,
- understanding the impact of new technology on life and work, and
- applying Consumer and Homemaking Education skills to jobs and careers.

Parents, especially single women who are employed heads of households, have been complimentary about the breadth and depth of the Consumer and Homemaking Education programs. They have said these programs have changed greatly in the past 20 years and they are extremely helpful in preparing their children to make good decisions regarding a whole host of issues such as nutrition, diet and health, consumer purchases and personal and family finances, avoiding substance abuse and teen pregnancy, and general concern for their school age peers as well as for their family members. All of these skills help their children to become independent, self-reliant, and contributing family members and citizens.

Of course, there are no easy solutions to all of our problems and concerns, but we also know that if we eliminate our emphasis on Consumer and Homemaking Education, turning our backs on these problems and pretending that they do not exist in our society, in essence we will be turning our backs on an opportunity for better prepared families and a better society. Our dream of a strong society will be at risk; for the family is the most basic institution of American society.

The philosophy underlying Consumer and Homemaking Education programs is that it is less expensive to teach families to manage resources and solve problems than it is to pay the social and financial costs of crisis intervention, malnutrition, and/or welfare. Successful management of resources in the family contributes to a worker's productivity in the labor market and, therefore, to the national economic growth and competitiveness. In order to increase economic growth and productivity, we need skilled workers who can manage scarce resources; vocational education trains such workers for the nation's labor force. The nation's defense programs require competent families, able to manage resources and solve problems. Consumer and Homemaking Education programs are the only comprehensive family programs consistently available in our nation's schools.

The emphasis of Consumer and Homemaking Education in 1987 is in the areas specified as priorities by Congress in the Carl D.

Perkins Vocational Education Act: food and nutrition; consumer education; family living and parenthood education; child development and guidance; housing; home management (including resource management); and clothing and textiles.

It is my intent here today to reinforce the importance of line item funding for Consumer and Homemaking Education; Consumer and Homemaking Education programs have great impact on the 3.9 million youth and adults they serve each year. These programs exist in approximately 33,000 schools and involve some 51,000 teachers. Consumer and Homemaking Education programs continue to serve twenty percent of the total school enrollment. There is some form of Consumer and Homemaking Education in nearly every community in the country that serves almost as many males, as females.

In conclusion Mr. Chairman and members of the subcommittee, because this program contributes significantly to national concerns and addressed national priorities, I urge you to continue funding for Consumer and Homemaking Education for fiscal year 1988 as a line item and increase from $31,633,000 the funding to at least $50,000,000, which, in 1988 dollars, is consistent with $43,497,000 appropriated in 1980. We appreciate your concern and support for these programs in the past. We believe you are pleased with the results Consumer and Homemaking Education programs have achieved with the Federal dollars invested and the state and local dollars they have generated; and because of these achievements, we trust you will see fit to increase the funding over the 1987 amount and continue it as line item funding.

STATEMENT OF JEWEL DEENE ELLIS, CHAIR, COALITION FOR VOCATIONAL HOME ECONOMICS EDUCATION PROFESSIONAL ORGANIZATIONS

I am Jewell Deene Ellis, Executive Director of the Kentucky Vocational Association and Chair of the Coalition for Vocational Home Economics Education Professional Organizations.

Thank you for the opportunity to discuss funding for vocational education, including Consumer and Homemaking Education.

Today, I am representing the Coalition for Vocational Home Economics Education which has a combined membership of more than 70,000 individuals from the American Vocational Association (AVA), the American Home Economics Association (AHEA), and the Home Economics Education Association (HEEA).

Historically funding to support Vocational Education and Consumer and Homemaking Education has been tied to the economic and educational priorities of the nation. Today is no different. Vocational education, including Consumer and Homemaking Education has a critical role to play in the success of six of the major goals of this country. It is significant that four of the goals are addressed in Part B, Consumer and Homemaking Education, Title III of the Carl D Perkins Law. The goals are:

- Competitiveness
- Retraining the work force
- Training special populations
- Basic skills development
- Improving educational quality
- Resolving social and education problems.

However, the President's budget for FY'88 proposes to eliminate funding for Vocational Education including Consumer and Homemaking Education. This action is puzzling and seems to be in direct conflict with the President's desire to provide support for American families. In the Proclamation of National Family Week in November, 1984 he said,

> "Family experiences shape our response to the larger communities in which we live. The best American traditions echo family values that call on us to nurture and guide the young, to help enrich the lives of the handicapped, to assist less fortunate neighbors, and to cherish the elderly. Let us summon our individual and community resources to promote healthy families capable of carrying on these traditions and providing strength to our society".

The President indicated further support of the family when in February, 1986 a working group in the Administration was asked to study how government at all levels could be more supportive of American families.

Funding for Consumer and Homemaking Education sends a clear message that the role of family life and functioning of households to economic, social and political well-being of our Nation is important. It has long been recognized that productivity in the work force is directly related to quality home and family life.

Consumer and Homemaking Education programs throughout the country are preparing 3.9 million students for the occupation of homemaking at all educational levels. Thirty-eight percent are males. These programs focus on preventive education and address social and economics concerns. Through these programs Americans can be productive citizens who pay taxes as contrasted to those who consume taxes through welfare and unemployment.

For the remainder of my testimony I want to focus on some examples which show the contribution that Consumer and Homemaking Education is making to the achievement of national goals.

COMPETITIVENESS

There is no doubt that a highly trained work force is essential if the United States is to meet its international competition. Consumer and Homemaking Education is and should be making a major contribution to this goal.

Kentucky and other states recognized the importance of the relationship of productivity to quality home and family life by requiring that instruction in Consumer and Family Life Skills be a component of training for all occupations at the postsecondary level. In Kentucky students enrolled in the 13 state vocational schools must participate in the program. Consumer Economic Skills, Life Skills and Employability Skills are taught in the 60 hour course. Each year approximately 3,000 students, both male and female, benefit from this instruction. Competencies in Consumer Economic Skills include developing and using a personal budget, understanding the services banks offer to customers, recognizing the sources of credit and the advantages and disadvantages of each, completing tax forms, discussing basic types of health, life, motor vehicles and home owners/renters insurance, and identifying ways to manage time, energy, skills and abilities. Priority competencies taught in Life Skills range from communicating with others, to changing roles of men and women and to dealing with family crises and responsibilities of parenthood.

RETRAINING AMERICAN'S WORK FORCE

It is projected that half of the current work force will be in new careers within five years and will require retraining. Again, Consumer and Homemaking Education can play a major role, especially in the retraining of displaced workers. For example, one state has provided assistance to "factory lay-offs". These individuals who were once in the middle income bracket are now the new poor who find themselves suddenly employed. Instruction varies according to the needs of individuals but topics having high priority are money management and consumer education. Many states with large numbers of "factory lay-offs" do benefit from this program.

TRAINING SPECIAL POPULATIONS

Section 312 of Part B, Title III of the Carl D. Perkins law specifies that grants for Consumer and Homemaking Education shall be used to conduct programs in economically depressed areas and to encourage participation of under-served populations. Consumer and Homemaking Education programs have exceeded this mandate. Over 50 percent of Consumer and Homemaking Education funding is spent in economically depressed areas. Of all the program areas in Vocational Education, Consumer and Homemaking Education serves more disadvantaged students than any other. Most of the students classified as disadvantaged are academically disadvantaged and lag behind as much as two levels in reading skills.

A random sampling of Consumer and Homemaking Education programs in Kentucky shows that the percentage of students who are disadvantaged ranges from 15 to 60. Perhaps the group to be hit the hardest by termination of Consumer and Homemaking Education funding would be the disadvantaged.

BASIC ACADEMIC SKILLS DEVELOPMENT

The integration and application of academic skills in Consumer and Homemaking Education continues to be a priority to ensure quality programs. Writing skills are practiced frequently as students prepare assignments. Written reports and evaluation of classroom and laboratory projects, invitations and thank you notes to resource persons and term papers are examples of ways students apply grammar, spelling and organization of ideas.

Reading skills are stressed through textbook assignments, product labels and directions, magazine articles and newspapers. Also library research is conducted in areas such as family relations, nutrition, consumer education and child development.

Application of mathematical skills is made in such areas as consumer education, food and nutrition, clothing and textiles, and housing and home furnishings. For example, consumer education provides opportunities for calculating interest on savings and loans, determining the cost of credit and figuring the cost of an automobile.

Consumer and Homemaking Education programs include scientific principles which provide personal meaning to learning. For example, science becomes alive for students in clothing and textiles as they learn how petroleum is used to produce today's modern textiles.

Analytical skills, also a part of Consumer and Homemaking Education, are developed through present-day and future oriented situations. In this context students have the opportunity to focus on the process of developing an ability to judge the validity of ideas, the viability of alternatives or the merits of solutions to problems. In addition the analytical process establishes a basis for rational thinking which enhances communication and understanding among and between individuals in the home and work place.

IMPROVING EDUCATIONAL QUALITY

Improving the educational quality of Consumer and Homemaking Education programs has definitely been the direct result of federal funding. Curriculum materials have been updated, revised and developed. Some of the newly developed curriculum is in the area of parenthood education, family violence and child abuse.

Inservice meetings for teachers conducted at regional, state and national levels have perhaps done more to improve the quality of programs than any other single activity. Up-to-date information in home economics subject matter including new technology is provided.

Another use of travel funds is supervision of students who are members of the vocational student organization, Future Homemakers of America. Two weeks ago I attended a state meeting of the Future Homemakers of America where 1400 students were in attendance. With the theme, "Voices of Tomorrow," several hundred competed for top awards in such categories as Illustrated Talks, Product Comparisons, and Job Interview. Concurrent sessions gave them opportunities to participate in discussions on dynamic leadership, teenage stress, careers and improving self concept.

For some institutions, program quality can be measured by the purchase and use of video recorders and video tapes. Tapes on family violence, parenting skills, teen stress, teen-age suicide, and teen-age pregnancy are well received and enhance learning. For other institutions quality means the purchase of computers and computer software.

And for four schools in Kentucky quality is piloting a semester class in nutritional science. Designed for high ability students, the class makes use of computer technology and involves various community agencies.

RESOLVING SOCIAL AND EDUCATIONAL ISSUES

Consumer and Homemaking Education programs have led the way in providing instruction that address societal concerns. Some examples of what is currently taught across the country are as follows:

- teen pregnancy and parenting
- teen suicide prevention
- nutrition education
- family violence
- drug and alcohol awareness
- coping skills/communication skills
- positive parenting
- latch key children
- career awareness
- elimination of sex bias and sex stereotyping
- family health
- balancing work and family

One of the critical education issues addressed by Consumer and Homemaking Education is the dropout problem. It is estimated that 30 percent or about one million of American's students never complete high school. Without some type of intervention such as a high quality Consumer and Homemaking program this trend will continue.

Over their worklives each dropout will add $26,000 to future social costs. As compared to high school graduates, dropouts will earn $247 billion less in wages during their life time. Those reduced salaries will cause a loss of $71 billion in taxes to local and state governments.

Evidence that Vocational Education and Consumer and Homemaking Education programs prevent students from dropping out is inconclusive. However, the number of dropouts who were once in a high school vocational program is less than the number of dropouts with similar backgrounds who were not involved in a vocational program.

Some of the strategies used by Consumer and Homemaking Education teachers to keep potential dropouts in school are the following:

- Involvement in the vocational student organization, Future Homemakers of America through special projects, committees, and attendance at regional and state meetings.
- Application of academic skills to "real life" situations, particularly for disadvantaged students.
- "Hands On" experience in the classroom.
- Use of teaching methods and techniques appropriate to the student's learning style.

Today, more than ever, our country needs workers who can balance work and family life. Because of this we can not afford to terminate funding for Consumer and Homemaking Education programs that focus on the future productivity of its citizens.

The time is now to increase the funding level for this program. In reviewing the funding history, the appropriation for FY'80 and FY'81 was $43,497,000. This amount was 53% authorization. In 1982 funding dropped to $29,600.000. Beginning in 1983 funding rose to $31,633,000 where it has remained. With the role that Consumer and Homemaking Education must continue to play in meeting national goals, I am recommending that line item funding for Consumer and Homemaking Education for FY'88 be increased to $50 million.

Mr. Chairman, I commend you and members of this committee for your support. I appreciate the opportunity to express the views of the Coalition regarding Consumer and Homemaking Education.

STATEMENT OF KERMETA "KAY" CLAYTON, VICE PRESIDENT, HOME ECONOMICS DIVISION, AMERICAN VOCATIONAL ASSOCIATION

Good morning, Mr. Chairman and members of the Subcommittee. My name is Kay Clayton. I am Associate Professor and Chair of Family Life Studies and Home Economics Education at The University of Southern Mississippi in Hattiesburg, and I am here as Vice President of the Home Economics Division of the American Vocational Association. Thank you for allowing me to speak this morning on behalf of the Consumer and Homemaking Education community which includes 50,000 home economics teachers and 3.9 million students, of which 300,000 are members of Future Homemakers of America vocational student organization.

We greatly appreciate the support that you have shown in the past for our programs. The President's FY 88 Budget proposes to eliminate funding for vocational education, including Consumer and Homemaking Education under Title III, Part B of the Carl D. Perkins Vocational Education Act (PL 98-524). The Administration has stated that the amount of Federal support is small and that this support could be assumed by the states. However, Federal dollars are extremely important because they generate State and local support to assist states in developing and implementing programs that focus on important national priorities and issues. In most states, elimination of the Federal presence would also mean elimination of Consumer and Homemaking

Education programs, and I am concerned that Mississippi would be one of many states affected.

I would like to recommend that funding be restored for this vital program. Federal funding for Consumer and Homemaking Education sends a clear message to state and local agencies that this program occupies a prominent place in education and specifically in vocational education. Federal dollars are the impetus for improving quality and for updating programs. In 1981, the recission reduced Consumer and Homemaking Education funding from $43,497,000 to $29,600,00; and these funds have never been completely restored. The major objective of Consumer and Homemaking Education programs is to prepare youth and adults (both males and females) for the occupation of homemaking. In so doing, Consumer and Homemaking Education clearly addresses several national priorities.

Economic development and productivity in this country are a great concern and have been identified as national priorities. The family has been called the basic productivity unit of society. It produces workers for the laborforce, family members for the home, and citizens for the community. Secretary Brock has called the family our "greatest national strength." It has become increasingly clear that productivity is enhanced when workers are able to cope effectively with the problems which arise from trying to balance the interrelated responsibilities of family and work. Consumer and Homemaking Education programs are helping young people as well as adults to develop the skills to achieve this balance.

In Ohio, for example, over 2,500 employees in 73 businesses have participated in "Work and Family Seminars" funded with Consumer and Homemaking Education funds.

These seminars are designed specifically to increase worker productivity and satisfaction. Seminar topics include the following:

- management of stress caused by work/family conflicts
- time and energy management at home and at work
- defining and managing the multiple roles of work and family
- communication and negotiation
- creative problem solving
- choosing and using child care
- working parents: quality time, guilt, and other issues
- special concerns of single parents

Similar workshops and seminars have been held in many other states, including Minnesota and Mississippi.

Another national priority is that of "at risk youth." Problems facing these young people include teen pregnancy and parenting, substance abuse, and family violence. The results are high drop-out rates and teen suicides. Consumer and Homemaking Educators in every state have taken these problems very seriously and are developing programs to meet the challenges. An example of an excellent instructional program is one offered through Ohio's Future Homemakers of America (FHA) organization. The organization sponsors the Teen Advisory Program (TAP) which helps young people cope with stress and pressure as an intervention to teen suicide. In 1985-86, this program reached 13,000 young people.

Teenage pregnancy prevention programs have been implemented in almost every state through Consumer and Homemaking Education, and the positive impact of these programs is being felt. Of particular note are programs in

Alabama, Mississippi, Arizona, Connecticut, Georgia, Massachusetts, Oklahoma, **Ohio, Michigan, Virginia, and Texas.** In 1985 in **Mississippi,** over **20%** of all live births were to teenagers between the ages of **10 and** 19, and **two-thirds** of these were to **unwed mothers.** Programs to alleviate this problem are now being offered through Consumer and Homemaking classes.

Another example is in **New Mexico** where Consumer and Homemaking Education monies are being used to help fund a community based interdisciplinary network called the **New Mexico Organization for Pregnancy and Parenting.** The network supports outreach projects to help communities identify their own problems and needs and then helps them develop a plan of action to address these needs. A statewide annual conference has been developed for consumer and homemaking teachers, guidance counselors, school nurses, public health nurses and physicians to enable them to address the issues of **teen pregnancy, parenting, and issues related to these problems.** Some 1200 professionals have been served through this program since its inception.

Florida has also implemented exemplary Consumer and Homemaking Education programs for **teenage parents.** In Broward County for instance, students attend special centers where they are taught **applied academic skills** through units in **parenting, child development and care, and resource management.** They are provided experiences in properly caring for their own children along with others. At the completion of the program, they may return to their original school; or they may continue in the special center until high school completion. Other excellent programs are found in counties all across the State of Florida.

Other national concerns being addressed through Consumer

and Homemaking Education are nutrition education and health issues. The national student organization, Future Homemakers of America, has as one of its program priorities a project called "The Student Body" which focuses on achieving and maintaining **individual and family health through exercise, proper nutrition, and avoidance of substance abuse.** In a growing number of states--beginning with **Oklahoma, Virginia,** and **California**--nutrition courses have been designed to take **a scientific approach;** and students may enroll in them to meet science requirements for graduation.

Concentrated efforts to address the problems associated with **sex bias and sex stereotyping** have been made in Consumer **and** Homemaking Education programs. Today, **males comprise 38% of the enrollment in these programs nationwide.** As an example, in **Alabama over 70% of the students** taking the course in "Home and Personal Management" at the 8th and 9th grade levels **are males.** In **Texas, males** comprise the **majority of students** taking courses in consumer education, home management, and family life education. A further signal of change is the election of **Tom Lucas from West Virginia** who is currently serving as **the first male President** of the 300,000 member **Future Homemakers of America** vocational student organization.

In response to a question from me about funding for Consumer and Homemaking Education for FY 88, **Bruce M. Carnes,** Deputy Under Secretary for Planning, Budget, and Evaluation in the U.S. Department of Education, stated that

> **priority was given to programs that enhance educational opportunities for the poor, the disadvantaged, the handicapped, and children of limited English-speaking ability; benefit children at the elementary and secondary levels;** improve the quality of American

> **education; and teach basic academic and literacy skills.** (Personal correspondence, March 27, 1987)

Historically, Consumer and Homemaking Education programs have served the **largest number of disadvantaged and minority persons of any vocational education program.** The Law requires that **1/3 of the funds** for Consumer and Homemaking Education be spent to provide programs **in economically depressed areas** or **in areas with high rates of unemployment.** In actuality, however, **over 50%** of the funds are used to support programs which serve youth and adults in these areas. Perhaps we might expect this in **Mississippi** where we have the lowest per capita income of any state and where 1/3 of our children live in poverty. However, **Illinois, Iowa, and Minnesota** and other states provide shocking examples of what is happening in today's economy in many parts of the country. Crises in the **oil industry, in manufacturing, and in farming** have resulted in **a depressed economy, high unemployment rates, family violence and stress, and "pockets of poverty"** where being poor was unthinkable only a short while ago.

Consumer and Homemaking Education programs in **family financial management, consumer education, employability, and stress management** provide students and their families with skills that they need for **survival** in today's world. A number of states have begun to develop and implement curricula which address the need for "skills for living and managing." These programs help students develop skills such as **critical thinking, problem solving, and decision making.** Some of the states that are offering this type of course include **Nebraska, Mississippi, Ohio, Alabama, Florida, Virginia, and Michigan**--to name only a few.

Another national priority addressed through Consumer and Homemaking Education is **applied learning**--or, the integration

and application of **basic academic skills.** Through assignments and projects, students in Consumer and Homemaking **Education** in every state develop their reading, writing, **and computation** skills. In addition, computers are utilized in most Consumer and Homemaking Education programs today, and computer literacy is quickly becoming commonplace.

The nature of the work force is changing rapidly primarily due to advances in technology coupled with the influx of large numbers of women. In today's world, **most women find gainful employment an economic necessity.** The single-parent family headed by a woman is becoming a common family form, and **one-half of all families living in poverty are headed by women.** Even though women have entered the world of work outside the home, they still continue to be the principal the homemaker.

Consumer and Homemaking Education strives to **prepare both males and females to assume multiple roles**--homemaker, wage-earner, and parent--in today's society. Programs at the **secondary level** take a **preventive** rather than a remedial approach. For **out-of-school youth and adults,** Consumer and Homemaking Education programs address the needs of **single parents and displaced homemakers** and are common in every state. Some of the more outstanding ones are found in **Kentucky, Ohio, and Mississippi.**

Another national priority addressed through Consumer and Homemaking Education is drop-out prevention. Like many other states, **Ohio** has developed programs for **disadvantaged youth.** The focus of these programs is on **enhancement of self-image and self-confidence, homemaking and family living skills, orientation to the world of work, and career awareness.** In **1985-86,** over 6,500 disadvantaged young people were served through these programs. **Twenty-one percent (21%)** showed improved school attendance, and 26% showed an improvement in their grades. Studies of the losses to society because of dropouts indicate that these losses range from $26,000 to $200,000 per dropout. Students who complete high school increase their earning capacity, thus increasing their chances of becoming productive, tax-paying citizens rather than welfare recipients.

Two other "at risk" groups--the very young and the elderly--are targeted in Consumer and Homemaking Education programs. Problems of latchkey children are being addressed in exemplary programs in Florida, Louisiana, Maine, and New Mexico, and Kentucky, while others are found scattered throughout the country. All Consumer and Homemaking Education programs include child development which is the study of human growth and development. These programs stress the care and guidance of young children relative to their physical, social, emotional, and mental growth and development.

Parenthood education emphasizes the development of skills which are necessary in performing parenting tasks. Because of society's growing awareness of the problem, child abuse is a topic often covered in child development classes. Kentucky has developed a model curriculum on the prevention of child and spouse abuse which is being adopted by a number of other states. Learning to choose quality child care has also become an important part of child development and parenthood education courses because of the growing numbers of working mothers and single-parent families.

Students in Consumer and Homemaking Education programs have always studied the family throughout the life cycle, but programs are increasingly focusing on the elderly. Population demographics point to the elderly as the fastest growing segment of society today. Families and the workplace have already begun to feel the impact of the aging populace, but the full impact will not be felt for another twenty years. Consumer and Homemaking Education funds are being used by states to develop new programs and curricula to help students understand the normal aging process and to deal with the problems that will be brought on by the increasing numbers of elderly. Issues facing the elderly and their families that are being addressed through Consumer and Homemaking Education are in the areas of housing and living arrangements, personal care, homemaking and management, nutrition, money management, and communication. States that are at the forefront in the development of programs which prepare students to work with the elderly include Iowa, Missouri, Connecticut, New Jersey, Florida, and Michigan.

Consumer and Homemaking Education is a unique part of vocational education in that its programs address the interrelatedness of the home, family, and work place. President Reagan himself elevated the family and homemaking to a national priority in his 1985 State of the Union addresses when he said that . . .

> Our progress began not in Washington, D.C., but in the hearts of our families, communities, workplaces, and voluntary groups which, together, are unleashing the invincible spirit of one great Nation under God. . . for an America of wisdom that honors the family, knowing that as the family goes, so goes our civilization.

Research continues to note that the connection between work and family is vital to the well-being of individuals and of the Nation as a whole. A worker's "quality of life" greatly influences his or her job satisfaction and productivity. As stated earlier, the family is the basic productivity unit of society, and work in the home continues to be a major factor in determining the strength of the labor market. Skills and competencies taught in Consumer and Homemaking Education are critical to the quality of life in the home as well as in the work place. The importance of the family to individuals cannot be overemphasized. A recent Gallup Poll reported that 90% of the respondents indicated that their family was the most important part of their lives.

Because Consumer and Homemaking Education contributes so significantly to the identified national priorities, I am recommending that line-item funding for this vital program (Title III, Part B, PL 98-524) be increased to $50,000,000 in the FY 88 budget. The Federal dollar serves as a catalyst in bringing about change, and it ensures that programs address national priorities. It contributes to the quality of programs when it is used

- **to attract and retain well-qualified state department of education supervisors,**
- **to support preservice and inservice education for teachers,**
- **to develop new and relevant curriculum materials,**
- **to fund research and exemplary projects, and**
- **to develop leadership through the vocational youth organization, Future Homemakers of America.**

Mr. Chairman, thank you for the opportunity to meet with you and this subcommittee to discuss **increasing the funding for Consumer and Homemaking Education under Title III, Part B of the Carl D. Perkins Vocational Education Act.** Federal funds appropriated to this program are dollars well spent, as documented in this testimony. Consumer and Homemaking Education is the only federally-funded education program available to our Nation's schools which focuses on families and the individuals comprising those families. Your continued support will be greatly appreciated.

STATEMENT OF JERRY MAULSON, LAC DU FLAMBEAU BAND OF LAKE SUPERIOR CHIPPEWA INDIANS

Good Morning, Mr. Chairman and members of the Committee. My name is Jerry Maulson, representative of the Lac du Flambeau Band of Lake Superior Chippewa Indians. Our reservation is located in the North Central part of the State of Wisconsin.

Since 1937 we have operated a Tribal Fish Hatchery Program that has maintained the fisheries resources of the reservation including 18,000 acres of lakes and 112 miles of rivers and streams. This management benefits Indians and non-Indians alike. Over the past six years we have greatly expanded our fish culture and management capabilities, wildlife management activities and conservation law enforcement and judicial responsibilities. Conservation codes and ordinances now support our regulatory objectives and increased management needs are being developed within a long range COMPREHENSIVE LAND USE PLAN. The key to the success of our intensive management effort has been an innovative education program. This VOC/TECH EDUCATION AND TRAINING PROGRAM began over three years ago, and was funded by a U.S. Department of Education Grant. It provided 23 Lac du Flambeau members with the opportunity to expand their fisheries culture and management expertise to become effective at producing the fish required to stock reservation lakes and to conduct the operational activities in collecting the information necessary to make wise decisions on the management of the resource. The degree of success that has been achieved by this program, as determined through independent evaluations by the UNIVERSITY OF WISCONSIN, has led us to develop an expansion plan to add WILDLIFE and FORESTRY curriculum to this VOC/TECH education and training program. In 1986, a lengthy proposal that had been developed by tribal planners over a two year period was submitted to the Department of Education. At that time we were limited to a request for funding for an 18 month program. Our request for 1.4 million dollars to construct the facility, staff it and operate it represented approximately 36 months of activity because of the constructional, developmental, and operational requirements as presented. Reviewer comments clearly indicated that a lack of understanding existed in relationship to the project. The Department of Education used this review process to disqualify us from receipt of the required funding. After requesting and receiving "REVIEWER COMMENTS" from the review process, it became quite apparent that the process had failed to adequately evaluate the extensive proposal that was submitted. It was inconceivable to us that a 200+ page document which required two years of development and which demonstrated supportive documentation from Tribal governments, regional educational institutions, and the State Department of Public Instruction, and which was based on a program with three (3) years of nationally recognized VOC/TECH educational expertise and successful experience in the field of natural resource education could be treated so lightly by the majority of the review panel. We must surmise that the lack of adequate funding at the Department level was instrumental in reducing the effort by the committee members in adequately evaluating the proposal and in providing financial support for the project. It was quite clear that the impact that this project will have on tribes nationwide was not considered in the final decision. We therefore fully intend to re-submit the proposal through the appropriate channels for review, but are requesting that Congress appropriate the 1.4 million dollars for the expansion and development of the LAC DU FLAMBEAU VOC/TECH EDUCATIONAL AND TRAINING PROGRAM. We further request that the U.S. DEPARTMENT OF EDUCATION be directed to work closely with the Lac du Flambeau Tribal Government to ensure that their program is adequately developed to receive the allocation being appropriated for the project.

A short description of the program will be helpful in establishing an understanding of the scope and the importance of Lac du Flambeau's proposal.

The Lac du Flambeau VOC/TECH Education and Training Program is designed to provide approximately 50 Native American students per year with the opportunity to receive up to two years of Forestry, Fisheries & Wildlife technician education and work experience. This opportunity will strongly emphasize marketable job skills that will lead to employment. These skills will be developed through work at the newly completed Lac du Flambeau Fisheries Facilities and on tribal lands for forestry and wildlife management activities.

The major need for this type of program exists because of the court appointed rights of tribes in CO-MANAGING the resources of this country. CO-MANAGEMENT requires trained and competent resource managers and technicians who will have employment with tribes as a result of funding appropriations from tribes, federal agencies and state governments. Lac du Flambeau intends to provide this educational opportunity to train NATURAL RESOURCE TECHNICIANS and will not be in competition with established Universities and Colleges. This distinction must be made to fully understand the impact of this proposal. This program will open the doors of education to many people who perhaps dropped out of school or never had the opportunity to consider advanced education. This proposal, through its support of the technical level of management with the Tribal Government will drastically increase the tribal goals of self-determination.

We have attached selected information from the VOC/TECH Education and Training proposal for your review. If you need any additional assistance, please contact MR. MICHAEL ALLEN, SR., Tribal Chairman.

STATEMENT OF EDWARD M. COONEY, DEPUTY DIRECTOR, FOOD RESEARCH AND ACTION CENTER

Mr. Chairman. Thank you for the opportunity of presenting this written testimony on the Community Food and Nutrition Program. My name is Edward M. Cooney, and I am the deputy director of the Food Research and Action Center (FRAC) in Washington, D.C. FRAC is an organization that works to alleviate hunger and poverty in the United States.

From 1974 to 1981, the Community Food and Nutrition Program (CFNP) supported a variety of public education, access, planning and direct delivery approaches to providing nutrition assistance for low income Americans. The 1981 Omnibus Reconciliation Act terminated the program, but Congress reauthorized CFNP in FY 1987 and provided $2.5 million for the program. The Office of Community Services of the Department of Health and Human Services administers the program.

Statewide anti-hunger organizations whose CFNP constituency includes food program recipients, nutrition program advocates, community action agency staff and the religious community, have always been viewed as the principal vehicle to effectively combat hunger and poverty. Statewide anti-hunger organization are in the best position to monitor the US Department of Agriculture's Food and Nutrition Services nutrition programs which represent this nation's commitment to eliminate poverty-related malnutrition. As pointed out by one former USDA Assistant Secretary for Food and Consumer Services: "There must be informed and aggressive actions statewide [emphasis added] and in communities across the country to monitor program implementation, to help governmental agencies do their jobs, and where necessary, insure that the law is enforced. Certainly we (USDA) intend to improve our capacity to aid in this process, but most of this work must be undertaken locally where only CFNP, and the volunteer work of other civic organizations, can be truly effective." (A Preliminary Report to Congress on CFNP by the Community Services Administration, January 15, 1980 (page 52).

It is quite clear that statewide anti-hunger groups, aided by CFNP, need to continue pursuing food and nutrition issues on behalf of low income people today. Currently, over 33 million Americans live below the poverty line and, as has been well documented, hunger is clearly a condition of poverty. The United States is the only industrialized nation where children make up the largest segment of the poverty population. The U.S. Conference of Mayors and others have recently released reports noting a significant increase in demand for food and shelter. Statewide food committees have been the most effective mechanism in meeting the needs of low-income people by providing the individuals and groups the tools to fight against hunger and poverty.

Currently the Office of Community Services of the Health and Human Services Agency distributes sixty percent of the $2.5 million appropriated for CFNP or approximately $1.5 million, solely to "statewide" grantees. The allocation formula is based on the number of poor and unemployed in each state. Forty percent or $1 million dollars will be allocated on a competitive basis to either statewide or local grantees. HHS distributes the funds for statewide projects through whichever state agency administers the Community Services Block Grant, (CSBG) while retaining direct control over the 40% funds.

Any state and local, public or private nonprofit agency can apply for funds. Grants are available for community-based, local and statewide programs:

1. to coordinate existing private and public food assistance resources, whenever such

coordination is determined to be inadequate, to better serve low-income populations;

2. to assist low-income communities to identify potential sponsors of child nutrition programs and to initiate new programs in undeserved or unserved areas; and

3. to develop innovative approaches at the State and local level to meet the nutritional needs of low-income people.

The distribution of the 40% funds through a competitive process at the Office of Community Services at HHS has been a model of quiet efficiency and exceptional expertise. OCS staff working on the discretionary grants have complied with the spirit and intent of Congress in issuing requests for proposals and timely obligation of appropriated funds as suggested in the Conference Report on the Human Services Reauthorization of 1986 HR 4421. The staff assigned to discretionary grants have prepared and timely released a very detailed but simple application for CFNP funds. They have also made themselves available to the general public for any assistance which potential grantees might require.

For some reason the OCS staff assigned to allocate CFNP to state agencies responsible for distribution of Community Services Block Grant funds have not been helpful in distributing information on funding available to statewide grantees. Very little guidance material and minimal staff involvement by OCS staff provided to state CSBG directors in the distribution of funds for "statewide grantees" has led to confusion at the state level over who qualifies for statewide funds under CFNP. In some states, it is clear that the spirit and intent of HR 4421 to award statewide funds to a statewide organization has been violated. In Texas, the Texas Department of Community Affairs divided the statewide CFNP funds among all CAP agencies pursuant to their normal CSBG formula apparently believing that awarding funds for "a statewide program" was equivalent to dividing up the funds among all Community action agencies in the state. The process effectively denied funding to the one genuinely recognized statewide anti-hunger organization in Texas, the Texas

Association of Community Action Agencies, Inc. Thus in Texas "statewide CFNP funds", necessary to combat hunger and poverty, went to every agency but the one capable of fighting hunger in the state as a whole. In Wisconsin, the CSBG state agency has indicated that the statewide CFNP funds will be substituted for previously granted CSBG funds. Thus the state's leading anti-hunger group, the Wisconsin Nutrition Project will receive no additional funds to fight hunger and poverty in Wisconsin. In Pennsylvania, Ohio, California and New York it does appear that statewide anti-hunger organizations which include program recipients, nutrition program advocates, community action agencies and the religious community will have an equal opportunity to receive CFNP statewide funds. In many other states, the process of selecting statewide grantees is simply unknown. In light of these events, I would recommend that the FY 1988 Labor-HHS-Education Appropriations bill contain specific report language regarding OCS distribution of CFNP funds to "statewide grantees." This report language should:

- include a definition of statewide grantee which will prohibit the division of "statewide funds to individuals CAA's (while allowing such agencies to apply for discretion funds) and prohibit substitution of CFNP funds for CSBG funds
- require HHS to file an annual report on who receives CFNP funds and what these groups accomplished with these funds in light of the allowable activities. OCS should be required to have an assessment mechanism in place using HHS funds to complete such an annual report.

STATEMENT OF EGLE V. GALLAGHER, PROJECT COORDINATOR, LEADERSHIP DEVELOPMENT FOR DISPLACED HOMEMAKER EDUCATION, UNIVERSITY OF SOUTH FLORIDA

This testimony is being delivered to Chairman Lawton Chiles and the Senate Committee on Appropriations on Labor, Health, Human Services and Education on behalf of displaced homemakers and single parents in vocational education. This testimony is intended to share perspectives on current efforts at the national and local levels (specifically Florida), and to inform policy makers at the national level of the needed funding for educational and employment programs for this targeted population, a population that represents over 6 million women in transition and the more than 2,000 training programs which serve them.

Displaced homemakers are generally women who have been caring for their homes and families and who must enter or re-enter the work force due to divorce, death or disablement of a spouse. Single parents have limited sources of income but also have custody responsibility of a minor child or children. These women are also in transition. They have diminished marketable skills as a result of having cared for their home and family. After years of work in the home, they are suddenly faced with the necessity of earning a living in the paid labor force.

The number of single heads of household who are women has increased from 4.5 million in 1950 to over 10.5 million in 1987. Today one of every four mothers in the labor force maintains her own family. Sixty-eight percent (68%) of women who head households with children under 18 were in the labor force in 1985. Although more likely to work, women with children under 18 had a considerably lower family income than women without children at home. The 1987 poverty line for a family of four is $10,609. A single mother working full time earns an average income of $6,968. After a year's work, the average single mother earns $3,641 below the poverty level.* According to the Department of Labor, 77% of the women employed are in non-professional, low-wage occupations earning minimum wage or below.

Characteristically, these women whether alone or responsible for dependents, children or spouses, have a common vulnerability: they all enter the labor force well behind every other segment of the population. They have inadequate educational preparation, traditional career socialization, making them competitive only in low wage earning jobs, lack of work experience, and they exhibit low self-esteem for facing the requirements of todays labor market.

Thanks to the foresight of Congress in 1985, funding has turned thousands of displaced homemakers/single parents from dependent burdens on our society, to a a position that will make them self sufficient-tax paying citizens. The Carl D. Perkins Act was particularly sensitive to funding programs, services and activities for single parents and displaced homemakers, which assist them in entering vocational training programs to gain marketable skills needed by them to enter the work force.

*National Commission on Working Women

It is especially important that perequisites be available to women and others facing multiple barriers to economic self-sufficiency, (displaced homemaker and single parent). Career information, motivational skills, child care/dependent care, literacy remediation, reliable transportation, support networks, marketable vocational skills, and job seeking skills are all necessary. Researchers agree these factors must be available in order for any individual to succeed in the work force. Displaced homemaker/single parent programs throughout the country include these components in their services for to these targeted populations.

Success stories of programs serving this population are characterized by unique collaboration efforts. Strong collaboration is required in both the Carl D. Perkins Vocational Education Act and The Job Training Partnership Act. Although each program has a special focus and service delivery mechanism, both should be committing significant public dollars to meeting the educational, training and employment needs of women - especially those facing multiple barriers to economic self-sufficiency.

The 1980 Census Data reported that 214,638 displaced homemakers in Florida over the age of 20 were living below the poverty level. An additional 118,215 were below the Bureau of Labor Statistics lower living standards. Thus, nearly 3/5 of the displaced homemakers in Florida are estimated to be unable to pay basic day-to-day living expenses. A 1982 survey in Florida indicated that 97 percent of those identified in the survey as displaced homemakers were not enrolled in a job-training program. *

In Florida over 100 programs located in school districts and community colleges in 1986 addressed the vocational training needs of this population. The following program data show that the influence of program activities to support the enrollment of women into vocational training programs in preparation for paid employment is evident.

- o 1984-85 enrollments showed an 18.7 percent increase in the number of males and a 32.3 percent increase in the number of females enrolled in training programs.
- o Women were primarily responsible for the 25.3 percent overall increase in 1984-85 enrollments.

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* Bromley, Ann; Florida Needs Assessment Study Focusing on Displaced Homemakers and Other Special Groups, Florida Department of Education, 1982

- The proportions of males and females enrolled in 1983-84 were 52 percent males and 48 percent females. For 1984-85 these proportions changed to 49 percent males and 51 percent females.

Although women have made significant gains in vocational enrollment patterns, displaced homemakers/single parents continue to be a difficult population to identify and serve because of the multiple educational and personal problems they face. In addition, occupational areas they are pursuing may limit their potential earnings.

In concert with efforts at the national level to encourage collaboration and cooperation between the service agencies of Carl D. Perkins Vocational Education Act and Job Training Partnership Act, the following models give emphasis to the need for continued cooperation of these efforts in Florida:

Program Models:.

Model #1: Lake City Community College, Lake City, FL

Lake City Community College offers a myriad of opportunities for meeting the social, emotional and educational needs of Baker, Columbia, Dixie, Gilchrist and Union counties' single parents and/or homemakers who are entering vocational skills training. The main objective is to assist in upward mobility and gainful employment in an occupation paying a high-wage and offering high-placement potential thereby combating the level of poverty in this target group.

The Consortium's FORUM Project (Focus on Rural Upward Mobility) provides an umbrella team approach that involves the coordination with the Department of Continuing Education, Division of Vocational Education and Job Training Partnership Program. Services provided are vocational assessment, counseling, tuition, textbooks, child care, transportation, and vocational placement based on individual interests and needs. Clients are referred to other agencies with like aims and services when appropriate.

Model #2: Chipola Junior College, Marianna, FL

Situated in rural northwest Florida, Chipola Junior College has a student enrollment of approximately 1,000. Response to the displaced homemaker/single parent program has been overwhelming, with more than 200 applications for services received in the first year of implementation. By linking campus resources with those from other agencies such as Job Training Partnership Act, Health and Rehabilitation Services, Job Services and community based organizations, Chipola was able to provide training and assistance funds for over 75 participants and child care and/or transportation for over 50 students.

Vocational education services for displaced homemakers/single parents at Chipola Junior College are designed to serve low income, unemployed or underemployed displaced homemakers and single parents. Outreach and instructional strategies focus on building self-concept, encouraging nontraditional career exploration and training for eventual high-wage placement.

In spite of the prevailing conservative attitudes concerning traditional female occupations, a public relations campaign and counseling program focusing on nontraditional career opportunities has increased nontraditional enrollments at Chipola Junior College. In one year, female enrollment in electronics technology more than doubled. Before the displaced homemaker program began, only one female student was enrolled in automotive mechanics. In contrast, females now comprise 25 per cent of automotive and 30 per cent of machine shop operations enrollment. In addition, 40 per cent of correctional officer training and basic law enforcement enrollees are now female while nearly one half of those taking criminal justice courses are women. Instructors report that women placed in nontraditional training are excellent students with an earning potential in this rural area of $7.00 to $9.00 per hour.

Model #3: New Beginnings, Polk Community College, Lakeland, FL
New Beginnings at Polk Community College is a model for cooperation and coordination among local agencies. The Polk Community College Health and Rehabilitation Service Displaced Homemaker Program (Choices and Options) and the Polk County School Board Single Parent and Sex Equity Programs are all under one roof. Coordinated services are offered from Heartland Private Industry Council, Job Services of Florida, Job Training and Partnership Act and many other agencies. Coordination of services and funding provides immediate help to people facing major life style changes so they can become emotionally and economically self sufficient. New Beginnings provides a warm, supportive atmosphere that encourages success, whether the client chooses immediate placement in a job or long-term self-development through commitment to educational and training options.

These models of focused planning by Carl D. Perkins Vocational Education Act and Job Training Partnership Act system administrators, policy makers, and service providers assure maximized services in vocational preparation, skill training and quality employment.

Data and program information indicate support for coordination efforts of the two systems, each with its own potential for serving displaced homemakers and single parents. In the case of the Carl D. Perkins Education Act, emphasis is on career commitment, especially technical and nontraditional training which offers high wages for potential and freedom from income inadequacy. In addition, these funds are directly aimed at increasing access of women and girls to vocational education services and eliminating barriers to active participation in the labor force.

Job Training Partnership Act, on the other hand, primarily targets Aid to Federally Dependent Children recipients and provides opportunity for short-term training and immediate job placement. Many Job Training Partnership Act clients, once literacy skills are increased and work attitudes matured, may be referred to programs supported by Carl Perkins Vocational Education funds.

Based upon information outlining problems and successes, the following recommendations are made:

- Alert policy makers that the two systems, Job Training Partnership Act and Carl D. Perkins Vocational Education Act, need to maintain their separate roles and purposes in serving the target population yet be encouraged to collaborate in developing these individuals as citizens, workers, and consumers.
- Oppose any reduction in funding for either system. This would only insure reduced services to this most difficult-to-serve population, thereby creating greater dependency upon welfare type programs for

future generations and compounding illiteracy and dropout problems.

- Ensure that all occupational training programs support and provide for the training of women as equal members of the potential work force.

Thank you for the opportunity to share these perspectives on collaboration and elaborate on Florida's efforts. Combined forces toward serving the nation's population of displaced homemakers and single parents can ensure programs that will supply trained workers to the nation's job market and enable self-sufficiency to a population group who might otherwise remain dependent members of society.

STATEMENT OF MARY ELLEN DELUCA, DIRECTOR, NEW YORK CITY URBAN CORPS

Mr. Chairman and members of this Committee, I am Mary Ellen DeLuca, Director of the New York City Urban Corps, the nation's first and largest College-Work-Study program. Since its inception in 1966, over 50,000 students from colleges and universities nationwide have taken part in the program. They have done so as a means to gain valuable experience, contribute to a community and supplement their income in order to pursue educational aspirations.

However, the benefits of a work-study program are not exclusive to the students. In a city such as that of New York, it is crucial to develop a citizenry knowledgeable in local government. One of the best ways of accomplishing this is by bringing together the city and its people to encourage the awareness and understanding of those issues facing local government.

It is with respect to the aforementioned that I present my views to the distinguished Senate Subcommittee on Appropriations for Labor, Health, and Human Services and Education concerning the proposed budget cuts in student financial aid and, specifically, the considered elimination of College-Work-Study funds.

The Fiscal Year 1988 Federal Budget would cut student financial aid by an unprecedented $3.6 billion. This represents a 46% decrease in aid to the neediest college students. Zero funding of College-Work-Study as proposed in the FY 1988 budget will have adverse effects on students nationwide. The possibility of supplementing their college education costs is denied and will either add on an even greater debt burden or prohibit the availability of higher education opportunities. In addition, our City government will no longer benefit from the talents and skills of students who contribute over 900,000 hours a year to public service agencies.

Presently, The City of New York pays 30% of each Urban Corps intern's salary while the Federal Government pays the additional 70% through work-study monies. It is because of this Federal funding that Urban Corps is able to hire students in a cost effective manner. Therefore, the proposed elimination of College-Work-Study funds will be felt by all, namely our local government, the academic community and the students who utilize the funds.

In summary, Mr. Chairman, although the budgetary decisions before you are inherently difficult, it is imperative that we do not lose sight of the subsequent effects of what is being proposed and considered. The right to an education has been hailed as a nation's means to realize the potential of its people. The budget proposals before you, if implemented, will not only eliminate a work-study program but will continue a detrimental trend of divestment in America's future.

I urge your support and commitment to the Federal College-Work-Study program and ask you to appropriate sufficient funds to insure its survival.

STATEMENT OF THE CHILD WELFARE LEAGUE OF AMERICA, INC.

The Child Welfare League of America appreciates the opportunity to submit testimony to the Subcommittee on Labor-HHS-Education with respect to several important child welfare programs.

As you may know, CWLA is a national privately supported organization comprised of approximately 500 public and private voluntary not-for-profit member agencies and 1600 affiliates who provide a variety of child welfare services to children and their families throughout North America. Such services include adoption, foster family care, residential treatment, group homes, day treatment, home-based social services and child day care. Included among our members, for example, are the Florida

Department of Health and Human Services; the Connecticut Association of Private Non-Profit Child Caring Agencies; the South Carolina State Department of Social Services; the New Mexico Human Services Department and The Coalition for Family and Children's Services in Iowa.

Many of our agencies provide residential and group care services to children who have been removed from their homes or who face the threat of having to leave their families. Tragically, the reason why many of these children come into care is because they have been abused or neglected by their parents. Because many of these children suffer from emotional as well as physical abuse, the care our agencies provide extends far beyond basic room and board. It includes counseling and treatment programs to help them develop normally, to realize their self-worth and full capacity as children and ultimately as productive adults in our society.

The ability for our agencies to provide these services and to insure the success of these children's lives, begins here --at the Federal level -- and is very much dependent upon the decisions made by this Subcommittee with regard to funding levels of the programs under your jurisdiction. All of these programs are important to agencies under the CWLA umbrella, but we would like to highlight a few that are especially critical.

Title IV-B Child Welfare Services is essential in helping our agencies keep children and families together. In 1980, P.L. 96-272 amended Title IV-B of the Social Security Act along with the Title IV-E Foster Care Program. At the time these programs were amended, the Federal foster care system was in crisis with approximately 500,000 children nationally reported to be "languishing" in out-of-home care. Many of these children were "lost in the system" with agencies having no idea who they were; where they were; or why they were there in the first place. Many of these children quite literally grew up in foster care, not having seen their families since the day they were first removed from their home. During testimony on P.L. 96-272, Congress learned that one reason for this was that there were few (if any) services available to either prevent the child's removal from the home or to help reunify the child with is or her family once removal has occurred. Child welfare workers had come to view foster care as the only option available to the child during a family crisis.

At that time, Title IV-B Child Welfare Services could be used for maintenance (i.e. room and board) payments for children in foster care. However, P.L. 96-272 amended Title IV-B by requiring that future appropriations could only be used for the purpose of establishing an array of child welfare services designed to: (1) prevent the unnecessary separation of children from their families by assisting in resolving problems and preventing family break-up; (2) reunify the family as quickly as possible when separation was appropriate; and, (3) place children in permanent adoptive homes where reunification with the biological family is not possible or appropriate.

Despite the fact that Title IV-B Child Welfare Services is currently funded far below its authorized level of $266 million (the FY 1987 appropriation level is $222.5 million) there is evidence that the program is beginning to achieve what Congress intended.

Therefore, in order to enable Title IV-B to be truly effective in addressing the needs of children and families in crisis, the Child Welfare League of America urges this Subcommittee to fund Title IV-B at its fully authorized level of $266 million.

Title IV-E Foster Care and Adoption Assistance are two important programs which provide for out-of-home care for children who are appropriately removed from their own homes and for subsidies for children with special needs who cannot be reunited with their families and for whom permanent adoptive families are found. Again, in terms of the intent of P.L. 96-

272, both programs appear to be working. In 1985, the national foster care population was reduced to approximately 275,000 compared to 502,000 at its peak in 1977. Conversely, the Adoption Assistance program has grown, in a remarkably short period of time, from FY 1982, when permanent adoptive families were found for 3800 children with special needs, to FY 1986, when an estimated 21,000 children with special needs were placed in adoptive homes.

With respect to the foster care program, shorter stays in care are evident -- in 1980, the median length of time a child spent in foster care was 27 months. In 1985, it was 18 months -a decrease of approximately 33 percent. More children are being reunited with their families -- in 1982, approximately 50 percent of children leaving foster care were reunited; by 1985, this figure increased to 67 percent.

The Child Welfare League of America supports and urges this Subcommittee to adopt the Administration's FY 1988 budget request of $97 million for the Adoption Assistance Program in order that it can provide continued support for children with special needs in need of permanent families.

However, the Child Welfare League of America opposes the Administration's FY 1988 budget proposal to limit administrative and training costs to 50 percent of states' maintenance costs with respect to Title IV-E Foster Care and Adoption Assistance Programs.

In support of its proposal to limit adminstrative and training costs in the Title IV-E programs, the Administration points up that, in the foster care program, administrative costs have increased in 16 states by over 1000 percent since FY 1981; that, for FY 1985, 22 states claimed foster care-related administrative expenditures equal to more than 50 percent of expenses for foster care maintenance payments; and, that 4 of these 22 states claimed greater expenditures for administration than for maintenance payments. It is interesting and important to note that FY 1981 marks the first year in which states began implementing P.L. 96-272. Moreover, given that allowable administrative costs as a result of P.L. 96-272, include such activities as, (with respect to foster care) referral to services; preparation for and participation in judicial determinations; placement of the child; development of the case plan; case reviews; case management and supervision; and recruitment and licensing of foster homes and institutions and, (with respect to adoption assistance) recruitment of and placement of the child in the adoptive home; case reviews during preadoptive placement; case management and supervision prior to the final decree of adoption; and, home studies. CWLA, therefore, submits that the fact that so many states have experienced increased administrative costs in both of these programs is an indication that states are providing to children the very protections intended by Congress in enacting P.L. 96-272 and which are in complete accordance with the law.

The Child Welfare League of America strongly urges that the Title IV-E Foster Care and Adoption Assistance Programs remain open-ended entitlement programs and urges this Subcommittee to reject the Administration's proposed savings in these programs based on any such legislative efforts.

In addition, we would like to call your attention to a program which was authorized under the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) as an extension of the existing title IV-E Foster Care Program -- the Independent Living Program. The authorization provides for $45 million in FY 1988 to enable States to establish transitional independent living programs for adolescents "aging out" of the foster care system. These are children for whom return to home or placement in an adoptive home is not appropriate. Once the federal or state subsidy is terminated, often as early as age 18, these youngsters quite literally have no where to go. Many end up as part of the homeless population, or on public assistance, or worse, as part of the prison population.

In FY 1987, the Congress, under the leadership of this Subcommittee, provided full funding of $45 million to implement this program in FY 1987. However, because HHS did not notify states how to apply for funds under this program until February of 1987 and only notified states that funds would be released in April of 1987, the program has been effectively delayed in its implementation for the full fiscal year. This program is critical in enabling older foster youth to make the transition from foster care to independence and funds must continue if we are to truly help such youth.

Latest (1984) national estimates are that approximately 50,000 foster care youth, between the ages of 16 through 18 would benefit from this program. The Child Welfare League of America, therefore, strongly urges this Subcommittee to recommend full funding of $45 million for the Title IV-E Foster Care Independent Living Program in FY 1988.

Title XX Social Service Block Grant is the primary source of federal assistance for a variety of social services including, for example, protective services and foster care for children suffering from abuse and neglect. It is also the major federal source of direct support for child day care for low-income working families. Other eligible activities include family preservation, transportation services, health support and appropriate combinations of service for children with special needs, the aged, the mentally retarded, the blind, the emotionally disturbed, persons with physical handicaps, and persons suffering from alcoholism and drug addition.

The Administration recommends that funding for Title XX continue to be frozen at $2.7 billion, as has been the case for the past three years.

CWLA urges an appropriation of $3.3 billion, for Title XX in FY 1988, as provided for in H.R. 1365. This bill proposes to restore funds that Congress intended be available to Title XX prior to the enactment of the Omnibus Budget Reconciliation Act of 1981. If funds are not restored, states will be unable to meet the need of their most vulnerable young, elderly and disabled citizens.

The Child Abuse Prevention and Treatment Act (P.L. 93-247) provides financial assistance for demonstration programs in the prevention and treatment of child abuse and neglect as well as grants to states for the purpose of developing and implementing child abuse and neglect prevention and treatment programs. The Administration has proposed that this program be consumed within a Social Services Discretionary program, which contains 25 other programs. The Administration requested $2.2 billion for its "discretionary" proposal which, if provided, presumably would be allocated among the 26 various programs however the Administration saw fit.

We believe that Congress should retain the decision-making as to the funding level of this program and therefore urge this Subcommittee to reject such a proposal. We further believe that at a time when the occurrence of child abuse has consistently risen for the last 8 years, that every effort should be made to strengthen and not diminish the administrative efforts of the federal child abuse program. The Administration's proposal provides no assurance that the child abuse program would be provided with sufficient funds so as to achieve this.

However, inasmuch as the legisltive authority for this program expires at the end of this fiscal year, CWLA is recommending the current funding of $26 million. We do, however, anticipate an increased FY 1988 authorized level over FY 1987 and should the reauthorization for this program be enacted prior to the passage of the Subcommittee's bill we would urge consideration be given to the higher funding level.

Adoption Opportunities (Title II of the Child Abuse Prevention and Treatment Act) is a program which provides funding to support activities aimed at eliminating barriers for the adoption of children with special needs. Funds are provided through the discretionary grant process for activities which generally support systemic efforts. An example of such efforts include, the funding of state-wide training activities aimed at recruiting homes for minority children with special needs who have the permanency planning goal of adoption. In addition, the Adoption Opportunities Program funds the national and several regional exchanges which provide photo-listing services for children who are waiting for a permanent family in order that such families might be identified for such children.

The Administration proposes funding this program as part of a larger Social Services Discretionary proposal which includes 25 other social services programs. The Administration has requested a total of $2.2 billion which, if approved by Congress, could be allocated among the various programs in anyway the Administration so chooses. We believe that Congress should retain the decision-making as to the funding level of this program and therefore urge this Subcommittee to reject such a proposal. Inasmuch as the legislative authority for this program expires at the end of FY 1987, there is currently no FY 1988 authorized level in law. Accordingly, CWLA urges this Subcommittee to fund the Adoption Opportunities Program at its current level of $5 million. However, should Congress reauthorize this program at a higher funding level prior to the completion of the FY 1988 appropriations process, we would urge this Subcommittee's consideration for funding this program at such level.

There are many other important programs for children that deserve attention but which we will only briefly outline as follows.

Authorized by the 99th Congress as Title II of the Children's Justice and Assistance Act of 1986, (which amends the Child Abuse Prevention and Treatment Act), the Temporary Child Care for Handicapped Children and Crisis Nurseries Program would provide needed parental support for parents with handicapped children and provide a necessary prevention service to parents at risk of abusing their children. CWLA requests an FY 1988 appropriation of $10 million to insure the implementation of this important program.

In the 99th Congress, two new initiatives were enacted as part of the reauthorization of The Education for All Handicapped Children's Act: (1) The Preschool Grant Program and (2) the Early Intervention Program.

The Preschool Grant Program constitutes a new state grant program for individuals from birth through age two who are developmentally delayed or, at the states' discretion, are at risk of developmental disabilities. The Administration's FY 1988 budget recommends no funding for this important program. CWLA recommends that the full authorization level of $75 million be appropriated in order that this program be implemented.

The Preschool Incentive Grant Program was created originally to provide encouragement by way of federal resources to state and local agencies to provide assistance to developmentally disabled children aged 3-5. The new program is intended to assist the states in ensuring that all children with disabilities within this age group receive special education and related servies by the school year 1990-91. The Administration's FY 1988 budget ignored the passage of this provision as well and further requested a rescission of almost $100 million from the 1987 appropriation with respect to the basic state grant program. CWLA requests an FY 1988 appropriation of $216 million for the Early Intervention Program which will insure services to all eligible children ages 3 through 5, as intended by Congress in the design of this program.

Further, CWLA urges the Subcommittee to reject the Administration's recission from the state grant program.

The Consolidated Omnibus Budget Reconciliation Act of 1985, increased the authorized level by $75 million for the Maternal and Child Health Block Grant (MCH) for purposes of expanded program activities to include primary health care services to children as well as community-based service network and case management for children with special health care needs.

The Administration's FY 1988 budget does not include this additional level and CWLA, therefore, urges this Subcommittee to reject the Administration's FY 1988 budget proposal and fund MCH at $553.3 million in FY 1988 which would include the additional $75 million, thus allowing the provision of such new services under this program.

The Developmental Disabilities Act is currently being reauthorized with the possibility of an increase in the authorized level from $85.2 million in FY 1987 to $104.6 million in FY 1988. Should the authorizing committee complete its work prior to the passage of an appropriations bill CWLA would urge consideration by this Subcommittee for funding this program at the higher level in FY 1988.

The Alcohol and Drug Abuse and Mental Health Block Grant is currently being reauthorized with the possibility of obtaining higher authorization levels in light of a new focus on drug abuse and homelessness in America. Should the authorizing committee not complete its work prior to the passage of an appropriations bill, CWLA would urge an FY 1988 appropriation for the ADM Block Grant of $495 million, its current funding level.

STATEMENT OF THE NATIONAL ASSOCIATION OF REGULATORY UTILITY COMMISSIONERS

This statement is submitted for the record to the Subcommittee on Labor, Health and Human Services, and Education of the Senate Committee on Appropriations on behalf of the National Association of Regulatory Utility Commissioners, otherwise known as the NARUC.

The NARUC is a quasi-governmental nonprofit organization founded in 1889. Within our membership are the governmental agencies of the fifty States, the District of Columbia, Puerto Rico, and the Virgin Islands engaged in the regulation of utilities and carriers. Our chief objective is to serve the public interest by seeking to improve the quality and effectiveness of government regulation.

The Association greatly appreciates this opportunity to make its views known on the Fiscal Year 1988 (FY88) appropriations for the U.S. Department of Health and Human Services (HHS). The NARUC is particularly interested in securing sufficient funding for the Low-Income Home Energy Assistance Program (LIHEAP) [42 U.S.C. 8621-29, Sections 2601-2611], since many of our members regulate the utilities affected by this legislation.

LIHEAP developed from Congressional efforts undertaken during the energy crisis of the 1970s to assist low-income households in meeting their energy needs. In the form of direct block grants, LIHEAP provides the States with significant flexibility in the administration of the program. Grants can be used to provide a variety of different types of heating and cooling assistance, as well as home weatherization and energy crisis assistance.

Each State establishes its own eligibility rules and benefit structure within broad Federal guidelines. In order to be eligible for assistance, a household must be either receiving other forms of public assistance (AFDC, SSI, food stamps, or certain veterans benefits) or must have an income below either 150 percent of the Federal poverty level or below 60 percent of the State's median income, whichever is greater. States are permitted to set lower liability levels, however, but may not exclude households with income under 110 percent of the Federal poverty level.

Funding for LIHEAP increased consistently over the first four years of the Reagan Administration, rising from $1.875 billion in 1982 to $2.100 billion in 1985. The 4.3% across-the-board Gramm-Rudman reduction reduced the 1986 appropriation slightly to $2.009 billion. For FY87, LIHEAP appropriations were reduced again. However the Conference Report on the FY87 appropriations bill stated: "The conferees wish to make clear that the amount agreed to for LIHEAP should not be construed as a decline either in support for the program or in the need for such assistance. Rather it is reflective of the unusual circumstances which exist this year: lower energy prices in general and the availability of substantial oil overcharge funds to the States."

Unfortunately, both the Department of Labor and the Department of Energy are projecting increases in residential energy prices for 1988. In addition, the vast majority of the oil overcharge money has already been distributed to the States and allocated to a variety of programs. Further distributions of oil overcharge money will be relatively modest and will be spread out over a period of several years. This, combined with an increase in the number of households below the poverty level, establishes a compelling case for appropriating the full $2.132 billion authorized for LIHEAP for FY88.

As State Commissioners who regulate retail electric and natural gas rates, our members are very sensitive to the burden increasing fuel costs imposes on consumers. We are especially mindful of the hardships these increases cause for the poor and the elderly. Escalating energy prices affect those least able to handle increased utility bills: the poor and those living off fixed incomes.

The findings of a June, 1986 study on LIHEAP prepared for the National Association for State Community Service Programs (NASCSP) demonstrate the depth and urgency of the need for increased energy assistance. The NASCSP study found that of an estimated 85.3 million households in the United States, 17.6 million met their State's eligibility standards for LIHEAP in 1984. These 17.6 million households had an average annual income of only $6,184 compared to the national average of $25,194. (That year the Office of Management and Budget set the poverty level for a family of three at $8,220.)

The average American family spends approximately four percent of its income on energy. Low-income households (150 percent of the poverty level or less), however, devote about 15 percent of their income to energy bills. In 1984, according to the NASCSP study, LIHEAP eligible households had average annual energy bills of $942. The average LIHEAP benefit that year was $213. It is also worth noting that 29 percent of the households which received assistance in 1984 were headed by a person 65 years of age or older with an average annual income of $5,188.

In addition to the small individual benefits, LIHEAP funds do not begin to reach all those eligible to receive them--even those who qualify under the stricter state eligibility requirements. The HHS July 22, 1986 report to Congress on LIHEAP stated: "The 6.8 million households receiving assistance with heating costs represent about 30 percent of all households estimated to have incomes under the maximum set out in [the LIHEAP statute]." Clearly, additional funding is needed.

By way of example, if the program were to try to focus on the very poorest of the poor, those whose household income is **below 50 percent of the poverty level**, and the rate of participation in the program among this group was 2/3 of those eligible, the NASCSP study calculates that LIHEAP funding of $2.5 billion per year would be required.

It is important also to address the fundamental problem of high usage of energy. Low-income households tend to need weatherization or conservation measures most. However, as demonstrated by current program limitations, eighty-five percent (85%) or more of most States' assistance funds are used to pay energy bills, often subsidizing waste and over-consumption. Additional funding should be made available to be used for conservation measures which would benefit the consumer, energy suppliers and the country as a whole.

LIHEAP is more than "lean". It is a program which is simply inadequate to address the real energy needs of low-income people. Appropriating the authorized amount of $2.132 billion for FY88 would be striking a sensible balance between the very real and urgent needs of poor Americans and the unquestioned necessity for fiscal austerity.

STATEMENT OF BILL STEINBERG, DIRECTOR OF REFUGEE EMPLOYMENT, LUTHERAN SOCIAL SERVICES OF SOUTHERN CALIFORNIA

The agency I represent, Lutheran Social Services, has been involved in assisting refugees from war torn and economically distressed nations to begin new lives in the United States for over one hundred years. For many decades refugee and immigrant resettlement was undertaken primarily by churches and community organizations. However, with the fall of Saigon in 1975 and the resultant flood of refugees from Indochina, the private sector was no longer able to effectively resettle the huge numbers of refugees arriving on our shores. The Refugee Act of 1980 formalized the resettlement process appropriately as a public and private sector partnership. The Act underscores the necessity of taking a discrete approach to refugee affairs on our shrinking globe. The Targeted Assistance Program is a unique public link in our public-private sector partnership designed to accomplish the ultimate purpose of resettlement which is refugee self sufficiency.

California has become the preferred state of resettlement for over one third of all refugees coming into this country. Fully ten percent of all refugees entering the United States have immediately settled in Los Angeles County. Additionaly, an estimated five percent of all this nation's refugees who innitially settled in other states have elected to resettle in Los Angeles County to be near family and countrymen already here.

Many of these refugees speak little or no English. Some are illiterate even in their own languages. Yet, we have been very successfull in placing a large number in at least entry-level jobs.

Preparing a refugee from a small fishing village in Indochina or a farm community in Afghanistan or Ethiopia to enter the very complex workforce in an area such as Los Angeles takes a very concentrated and committed effort from both the public and private sectors.

Lutheran Social Services, along with a number of other voluntary organizations including Catholic Welfare, the Hebrew International Aid Society, Church World Services and International Rescue Committee have responded to these new needs by establishing employment and job placement services that assist the refugees into their first jobs. Through our Church and community contacts we have located private sector employers who are willing to take a chance on hiring a refugee and giving him or her the first step on the ladder to self sufficiency and a return to self respect and personal dignity. Given the very large numbers of refugees needing this assistance, it is only through a partnership of the public and private sectors that the completion of the resettlement process can be accomplished.

The Targeted Assistance Program has served as a catalyst to church and community based organizations such as my own to continue their mission of assisting refugees in their first hard days and months in this country. Continued Congressional support of Targeted Assistance signals the clear intent of our nation to not abandon our committment to these needy people. We urge your support for funding of Targeted Assistance in the Fiscal Year 1988 budget.

STATEMENT OF NGUYEN "ANDY" ANH, EXECUTIVE DIRECTOR, ECONOMIC AND EMPLOYMENT DEVELOPMENT CENTER FOR CAMBODIAN, LAO AND VIETNAMESE COMMUNITIES

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM NGUYEN 'ANDY' ANH, EXECUTIVE DIRECTOR OF THE ECONOMIC AND EMPLOYMENT DEVELOPMENT CENTER FOR CAMBODIAN, LAO & VIETNAMESE IN LOS ANGELES COUNTY, CALIFORNIA. I WAS BORN AND RAISED IN VIETNAM AND AM NOW A PROUD CITIZEN OF THIS GREAT COUNTRY, THE UNITED STATES OF AMERICA. I SPEAK AS A REPRESENTATIVE OF THE EMERGING NETWORK OF REFUGEE SELF-HELP AND SERVICE ORGANIZATIONS.

I SHALL SPEAK TO THREE POINTS, SUPPORTING THE TARGETED ASSISTANCE PROGRAM (TAP):

1. THE PROGRAM MEETS A REAL NEED FOR REFUGEES, A MAJOR STEP TOWARD THE ULTIMATE PURPOSE OF REFUGEE RESETTLEMENT WHICH MUST BE REFUGEE SELF-SUFFICIENCY.

2. THE TAP PROGRAM, MORE THAN ANY OTHER COMPONENT OF THE REFUGEE EFFORT SINCE 1975, HAS BUILT CAPACITY IN THE REFUGEE COMMUNITIES BOTH THROUGH REFUGEES CREATING JOBS FOR REFUGEES AND IN THE VOLUNTARY CAPACITY OF REFUGEE ORGANIZATIONS TO SERVE THEIR OWN COMMUNITIES.

3. TAP IS NOT SIMPLY A DOMESTIC PROGRAM BUT ALSO AN IMPORTANT PART OF U.S. FOREIGN POLICY. THE EYES OF CRITICAL AREAS OF THE WORLD WHERE THERE ARE MAJOR CONCENTRATIONS OF REFUGEES SUCH AS SOUTHEAST ASIA, ARE WATCHING AND INTERPRETING WHAT YOU DO HERE.

I WISH TO CONFIRM THE NEED FOR THE TARGETED ASSISTANCE PROGRAM. LAST SUMMER, I WAS PRIVILEGED TO PARTICIPATE, WITH MY FELLOW AMERICANS, IN THE CELEBRATION OF THE CENTENNIAL YEAR OF THE STATUE OF LIBERTY. THE GREAT AMERICAN SONG AND SYMBOL OF THAT EVENT COMMEMORATED FOR MY REFUGEE FRIENDS AND I, NOT SIMPLY OUR AMERICAN HERITAGE OF LIBERTY, BUT A LIVING MEMORY. THE REFUGEES, INDEED, HAVE BEEN THE "TEMPEST TOST, YEARNING TO

BREATHE FREE." WE BELIEVE THAT OUR ARRIVAL HERE AND OUR NEW BEGINNINGS HERE ARE OF THE ESSENCE OF WHAT AMERICA IS ABOUT. BUT AS YOU WELL KNOW, THOUSANDS OF REFUGEES ARRIVE WITHOUT THE LANGUAGE, KNOWLEDGE OF CULTURE AND WORK SKILLS NECESSARY FOR SURVIVAL IN AMERICA. FOR THOSE THOUSANDS, TAP IS THE LAST AND CRITICAL STEPPING STONE TO THE SELF-RELIANCE THAT IS ESSENTIAL TO THE AMERICAN TRADITION OF FREEDOM.

MAY I MAKE WHAT I TRUST WILL BE SEEN AS AN HONORABLE COMPARISON. THE UNITED STATES HAS DEEMED IT A WISE INVESTMENT TO ASSIST AMERICAN VIETNAM VETERANS IN EDUCATION AND IN THEIR EMOTIONAL WELFARE. THE G.I. BILL, SINCE ITS INCEPTION, HAS BEEN SEEN AS AN INVESTMENT IN AMERICA. MAY I SUGGEST THAT TAP IS ALSO AN INVESTMENT IN AMERICA, ENABLING THOUSANDS OF NEW AMERICANS TO BECOME PRODUCTIVE, SELF-RELIANT MEMBERS OF THEIR SOCIETY. SECONDLY, I WOULD UNDERSCORE THE CAPACITY BUILDING FEATURES OF THE TAP PROGRAM. TAP HAS PROVIDED A MEANS FOR FINDING AND DEVELOPING JOBS WITHIN THE REFUGEE AND IMMIGRANT COMMUNITIES. IT HAS ALSO PROVIDED A MEANS FOR INVOLVING SOME OF THE HISTORIC AMERICAN MINORITY COMMUNITIES IN PROVIDING JOBS FOR REFUGEES SUCH AS THE CHINESE AND JAPANESE COMMUNITIES OF SOUTHERN CALIFORNIA. REFUGEE BASED ORGANIZATIONS ARE A SIGNIFICANT PART OF THE TAP PROVIDER NETWORK. A SECONDARY BUT IMPORTANT BENEFIT OF THE TAP PROGRAM, BEYOND THE PRIMARY PURPOSE OF JOB PLACEMENT, IS THE CAPACITY BEING BUILT IN REFUGEE ORGANIZATIONS TO SERVE THEIR COMMUNITIES. THIS CAPACITY WILL PROVIDE IMPORTANT RETURNS IN THE DECADES AHEAD IN ENABLING THE REFUGEE COMMUNITIES TO HELP THEMSELVES AND SERVE THEIR INDIVIDUAL MEMBERS.

FINALLY IT IS IMPORTANT TO RECOGNIZE THE IMPLICATIONS OF SUPPORTING TAP AS A POSITIVE STATEMENT OF U.S. CONCERN INTERNATIONALLY FOR REFUGEES AND HUMAN WELFARE ISSUES. I REMEMBER WHEN THE U.S. WAS TURNING BACK THE CUBANS AND HAITIANS TO THEIR HOMELANDS. GIVEN ALL THE COMPLEXITY OF THAT SITUATION, IT WAS VIEWED AS AN INCONSISTENCY IN AMERICAN POLICY WITH REGARD TO REFUGEES IN THAILAND, WHERE THE U.S. WAS ENCOURAGING THAIS TO KEEP THOUSANDS OF LAOTIANS AND CAMBODIANS IN REFUGEE CAMPS WHO WERE CROSSING THE THAI BORDER, RATHER THAN RETURNING THE REFUGEES TO THEIR HOMELANDS. THIS INCIDENT, WITH ITS SEEMING INCONSISTENCY, AND MOST REFUGEE RELATED EVENTS, ARE CAREFULLY REPORTED IN THE BANGKOK TIMES. IT IS INDEED A SHRINKING GLOBE WHERE AMERICAN ACTIONS WITH REGARD TO REFUGEES CAN BE INTERPRETED IN WAYS WE MIGHT NOT CHOOSE. NONETHELESS, SUPPORT OF TAP, WHILE FIRST AND FOREMOST MEETING A DOMESTIC NEED FOR REFUGEE SELF-SUFFICIENCY, IS ALSO A POSITIVE INTERNATIONAL MESSAGE OF AMERICAN REFUGEE CONCERN IN SUCH SENSITIVE AREAS OF THE WORLD AS THAILAND.

IN CONCLUSION, TAP MEETS A CRITICAL NEED IN ENABLING REFUGEES

TO BECOME SELF-SUFFICIENT. IT IS A CAPACITY BUILDING EFFORT, GENERATING INDIVIDUAL PRODUCTIVITY AND THE SELF-HELP ABILITY OF REFUGEE COMMUNITIES. SUPPORT OF TAP IS A POSITIVE MESSAGE, DOMESTICALLY AND INTERNATIONALLY, AS TO WHAT AMERICA STANDS FOR WITH REGARD TO LIBERTY AND HUMANITARIAN CONCERN.

THANK YOU VERY MUCH.

STATEMENT OF JOAN PINCHUK, REFUGEE COORDINATOR AND DIRECTOR, REFUGEE TARGETED ASSISTANCE PROGRAM

Mr. Chairman and Members of the Subcommittee, I am Joan Pinchuk, Los Angeles County Refugee Coordinator and Director of the Refugee Targeted Assistance Program in Los Angeles. I appear here today in support of including $48 million in the 1988 Fiscal Year budget for the Refugee Targeted Assistance Program for impacted areas nationwide.

The funding of this program is most needed and warranted because it will continue to provide employment/training programs for refugees/entrants to help them become self-sufficient and reduce their dependency on welfare. The specific reasons for requesting the continued funding of Refugee Targeted Assistance are as follows:

-- California, in particular Los Angeles County, has a disproportionately high concentration of refugees. Nationwide, Los Angeles County receives 1 out of 10 refugees initially resettled in this country.

-- The Refugee Targeted Assistance Program has proven to be successful, by placing 6000 refugees in unsubsidized jobs and saving well over $6 million in welfare costs for a 15-month projected period.

-- The Administration has proposed to unfairly shift the costs of refugee resettlement and self-sufficiency to

local governments by proposing the reduction of refugee service funding nationwide, from $116.5 million in 1986 to $45.5 million in 1988.

-- **Los Angeles County does not have the resources to fill the gap that will result if the budget cuts proposed by the Administration are adopted.**

I would like to provide the following information on the above points:

LOS ANGELES COUNTY HAS LARGEST REFUGEE POPULATION IN THE USA:

Of the total refugee admissions to the United States, Los Angeles County has received a minimum of 1 out of 10 refugees. This amounts to at least 6000 refugees a year initially resettled in Los Angeles County. In addition, it has been estimated that another one third of the county's refugee population came from other states. This has been substantiated by statistics gathered by the Targeted Assistance Program.

TARGETED ASSISTANCE HAS PROVEN SUCCESSFUL IN PLACING REFUGEES IN UNSUBSIDIZED JOBS:

For the three years that Targeted Assistance has operated in Los Angeles County, the following results have been seen:

1. **Refugees have been diverted from seeking and receiving public assistance.**

   Over 4400 adult refugees who were not on welfare but who were at or below the poverty level were placed in jobs that supported themselves and their family. Consequently, persons were diverted from the welfare system resulting in substantial savings.

2. **Refugees were able to terminate or reduce their public assistance benefits due to employment.**

   During the past three years, approximately 1500 refugee welfare cases or over 4000 refugees have had their welfare check terminated or reduced as a result of their obtaining employment through the Targeted Assistance program. In computing the welfare savings, it is estimated that over $6 million has been saved during a 15-month projection.

The job retention rate of the refugees obtaining unsubsidized employment has also proven quite high. It was found that close to 70% were still working 90 days after placement. Ninety days consecutive employment has been the criteria for success in Targeted Assistance whereas other programs only follow the participants' job progress for 30 days.

3. **The program has cost less than $3500 per refugee placed in employment.**

Each refugee who received counseling and training that ultimately resulted in a job placement, cost less than $3500 per refugee. This compares to the cost of $7000 a year in welfare benefits for a family of three where the head of household has no job. In addition, other mainstream programs that do not primarily serve difficult-to-place persons may cost $4400 plus, per person placed. The refugee participants served by Targeted Assistance have numerous barriers to employment, such as:

1. One quarter (1/4) have fair to no English at all;
2. Over one third (1/3) had dropped out of school or have no education to speak of;
3. One third (1/3) have large families of four or more, and
4. Over one half (1/2) have been in this country less than three years.

COSTS FOR SERVICES TO REFUGEES ARE UNFAIRLY BEING SHIFTED TO LOCAL GOVERNMENTS

The funds for the Refugee Social Services and Targeted Assistance Programs have been proposed to be cut by the

Administration from $116.5 million in 1986 to $45.5 million in 1988. This places a burden on local governments to help this new population become self-sufficient and complete the resettlement process. With such drastically reduced funding, resources will not be available and this new population may have to resort to receiving welfare to support themselves and their family rather than obtaining the specialized help they need.

Additionally, the Administration is proposing reducing the time eligibility of the refugee population to 24 months, one year less than authorized by the Refugee Reauthorization Act, shifting the costs to local government for welfare benefits.

LOS ANGELES COUNTY DOES NOT HAVE THE RESOURCES TO MEET THE EMPLOYMENT TRAINING NEEDS OF THE REFUGEE POPULATION

Los Angeles County does not have the ability to fund refugee employment/training programs due to:

1. **Loss of $80 million in federal revenue sharing funds;**
2. **Expenditure of over $120 million in general fund revenue for Los Angeles County's homeless population, which is the largest in the country.**
3. **Additional public health system costs to serve AIDS patients. The Center for Disease Control states that one out of 12 AIDS patients reside in the Los Angeles area.**
4. **Costs that will be incurred as a result of the Immigration Reform and Control Act of 1986 are estimated to be $182 million in Los Angeles County. In a study by the U.S. Census Bureau, 1/3 of all undocumented aliens in the country reside in Los Angeles County and it is believed that the total costs for their health and welfare needs may not be totally met by the federal legalization assistance block grant.**

In conclusion, we encourage your support for including $48 million in the 1988 FY budget for the continuation of this most needed employment training program for refugees. It is believed that without this specialized employment/training program which serves the bilingual/bicultural refugee population, many refugees will not have the opportunity to obtain the skills and know-how they need to be functional and productive residents of this country.

STATEMENT OF THE NATIONAL ASSOCIATION OF REHABILITATION PROFESSIONALS IN THE PRIVATE SECTOR

The National Association of Rehabilitation Professionals in the Private Sector (NARPPS) represents over 10,000 individuals who are rehabilitation service providers, educators, administrators and other parties interested in maintaining and increasing the efforts of the Federal government and the private sector in providing vocational rehabilitation services to Americans with disabilities in assisting them in returning to work.

NARPPS knows that there are profound differences between the self-perception of disabled persons who are working vs. the self-perceptions of disabled persons who are not working.

NARPPS knows that persons with disabilities who are working feel better about themselves than persons with disabilities who are not working.

NARPPS knows that persons who are working feel better about life than other persons with disabilities who are not working feel about life.

NARPPS feels that there should be an increased effort to identify those disabled Americans whatever the cause of their disability who have the potential to return to some type of productive work and independent living.

NARPPS recommends and supports the idea that new ground should be broken in regard to the delivery of rehabilitation services to Americans with disabilities.

NARPPS feels that there should be linkage and coordination of the existing Federal rehabilitation plan and linkage and cooperation between the traditional State-Federal rehabilitation service providers and the non-traditional rehabilitation private sector rehabilitation service providers in the United States.

Future consideration should be given to funding the utilization of private sector rehabilitation to work with selected target populations of disabled Americans such as Social Security Disability Insurance recipients, Disabled American Veterans and economically displaced American workers.

NARPPS recommends and supports the measurement of outcome of all rehabilitation service providers in both the public sector and the private sector.

NARPPS supports the following for fiscal year 1988 authorizations:

1. $1,409.1 million for vocational rehabilitation state grants.
2. $33 million for rehabilitation training.
3. $52 million for the National Institute on Disability and Rehabilitation Research.
4. $26.47 million for supported employment services for individuals with severe handicaps.
5. $27.4 million for special demonstration projects.
6. $17 million for projects with industry.

STATEMENT OF THE NATIONAL COUNCIL ON REHABILITATION EDUCATION

National Council on Rehabilitation Education (NCRE) is an organization composed of rehabilitation educators, training specialists and researchers. We prepare and maintain the competencies of a variety of rehabilitation personnel who assist a portion of the 36 million Americans with disabilities who require professional service to remain or become employable and functionally independent. The National Council on Rehabilitation Education works in concert with the Council of State Administrators of Vocational Rehabilitation (CSAVR), the National Council of State Administrators of the Blind (NCSAB), the American Rehabilitation Counseling Association (ARCA), the National Rehabilitation Counseling Association (NRCA), the President's Committee on Employment of the

Handicapped (PCEH), the Association of Educators for Rehabilitation Facility Programs (AERFP) and other members of the Rehabilitation Coalition.

Importance of Rehabilitation Education, Training and Research to Rehabilitation. Life for people with disabilities involves striving, working, taking risks, failing, learning and overcoming obstacles, no different than it is for other Americans. At one time or another we have all experienced seeking something that eludes us, of trying to reach a goal that seems to remain just out of reach. Most of us have also had the rewarding experience of surmounting obstacles to achieve a goal or accomplish a task, succeeding even though someone else or even ourselves doubted we could do it. A major difference between persons with disabilities and other individuals is the number, degree and complexity of the barriers they face in trying to achieve their personal goals and fulfillment.

Equality and independence have been fundamental elements of the American form of government since its inception. The rights to equality of opportunity and to personal independence have been recognized and protected in the Declaration of Independence, the Constitution of the United States, the constitutions of the individual states, and in the laws enacted by the U.S. Congress. As a nation, we have committed ourselves to assisting persons with disabilities by establishing in every state and territory rehabilitation programs jointly financed by federal and state funds. The federal/state programs have been both cost-effective and successful in stressing services instead of support, rehabilitation instead of relief and training for useful work instead of prolonged dependency.

The qualified rehabilitation practitioner is the pivotal service provider in the federal/state rehabilitation programs and rehabilitation facilities. The qualified rehabilitation practitioner is responsible for aiding persons with disabilities by assessing their abilities and interests, understanding their needs, adjusting to their handicaps, and obtaining employment consistent with their capacities and capabilities. "Qualified" is the key word. Qualified indicates the practitioner is performing a needed function, knowledgeable and skillful, trained, ethical and involved in continuing education to keep abreast of the most recent advancements in service delivery. Qualified rehabilitation practitioners must possess special knowledge and skills. These knowledges and skills are acquired through specialized pre-service education, continuing education and in-service training.

A complimentary relationship among research, pre-service education, continuing education and service has been successfully implemented since rehabilitation training was authorized by Congress in 1954. The result has been an impressive network of pre-service and continuing education programs based in colleges and universities, and in-service training resources of the federal/state programs which are responsive to the preparation and continuing training needs of the qualified practitioner and enable practitioners to implement a comprehensive program of services for this nation's citizens with disabilities.

Rehabilitation training grants, a critical element in providing appropriate services to persons with disabilities, are made to institutions of higher education and other public or non-profit agencies and organizations to help ensure that qualified personnel are available to provide rehabilitation services to persons with disabilities. Persons with disabilities deserve the opportunity and have the right to receive rehabilitation services from qualified professionals. Rehabilitation plans are tailored to each person with a disability, vocational rehabilitation depends upon well prepared, qualified professionals to deliver a wide range of services. Rehabilitation training through pre-service, continuing education and in-service training supports rehabilitation counseling, vocational evaluation, rehabilitation facility administration, rehabilitation facility and workshop personnel, interpreters for persons who are deaf, personnel to serve persons who are blind, medicine, nursing, and engineering.

Importance of Full Funding. The programs established under the Rehabilitation Act include a careful balance of research, education, training and service delivery components, each of which strengthens and reinforces the others. The success of the rehabilitation program and the quality of services to persons with disabilities depends on the availability and maintenance of qualified personnel. Congressional recognition of and commitment to a strong rehabilitation training program indicate congressional intent is not to curtail federal involvement in rehabilitation training, but to strengthen and improve the effectiveness of the program. The Administration's funding request and policies run counter to this intent and threaten the viability of rehabilitation training and the quality of services available to the disabled. Following the course proposed by the Administration, the supply of trained qualified rehabilitation personnel will be reduced by fewer graduates and the ability to upgrade the knowledge and skills of employed personnel will be reduced, diminishing the quality of services to citizens with disabilities.

The Administration recommends only $25.84 million for rehabilitation training. This is 7.16 million or 22% less than Congress authorized for FY 1988, and is 3.8 million or 12.8% less than Congress appropriated in FY 1987. The Administration contends "available data on personnel shortages do not support appropriation increases." Contrary to the Administration's contentions, data is available which demonstrates and supports the need for increased funding. The Administration has chosen not to utilize available data. If you accept the Administration's approach and lack of understanding of the needs for rehabilitation training, rehabilitation efforts will be critically damaged.

Recommendation. The National Council on Rehabilitation Education recommends that the Congress fully fund the Rehabilitation Training Program at $33 million for FY 1988.

Justification. Disabilities present major barriers to employment and independent living for persons with disabilities. These barriers can be overcome with the services of qualified rehabilitation professionals. Our experience and research evidence over the last thirty-four years demonstrate without a doubt that pre-service, continuing education and in-service training is essential to ensure qualified professionals will be available to provide an effective, efficient delivery of services to citizens with disabilities.

A fundamental element of our country is that equal opportunity, equal access to all aspects of society and equal rights guaranteed by the Constitution be provided to all persons with disabilities. It is essential that persons with disabilities are able to live their lives independently, with dignity and that the complete integration of all persons with disabilities into normal community living, working and service be given the highest priority. It is of critical importance to provide full funding for rehabilitation education and training as it is the only way to guarantee that persons with disabilities receive services from qualified rehabilitation practitioners.

STATEMENT OF THE ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION

Chairman Chiles and distinguished members of the subcommittee, this testimony is being submitted on behalf of the Association for Gerontology in Higher Education (AGHE). AGHE is a nonprofit membership organization of approximately 280 institutions of higher education that conduct research and provide training and education in the field of gerontology. This testimony will address the proposed FY 1988 budgets of the Administration on Aging, Title IV (OAA) programs; the Health Resources and Services Administration, Bureau of Health Professions; the National Institute on Aging; and the National Institute on Mental Health, Mental Disorders of the Aging Branch.

Once again, our country's political leaders must struggle with the dilemma of dividing scarce resources between those programs which have long-term payoff and those programs which have a quick, visible, and dramatic impact on the society and the economy. As an association of educators we must emphasize the need to spend money wisely by adequately preparing for the future. At this time, the federal responsibility for assuring the development of a research base and a supply of trained professionals in the field of aging must be reaffirmed.

We thank you for your support over the past several years and ask that you continue to be advocates for improving the lives of Americans of all ages through the continuation of the unique education, training, and research programs which the budgets of these four agencies fund.

Importance of Aging Education, Training, and Research. We argue that of equal value to service programs for older Americans are the (a) research activities which expand our knowledge about the aging process, (b) the demonstration projects which enable more appropriate and efficient service programs to be designed, (c) educational programs which prepare professionals to work in the field of aging, and (d) continuing education and training programs which upgrade the skills of persons already serving the elderly and their families.

Without these "supportive" programs the service delivery activities will most likely be ill-conceived and inappropriate and will be staffed by persons who do not understand the aging process, how to work effectively with older adults and their families, or how to be efficient administrators. The waste of fiscal and human resources which occurs when planning is uninformed and personnel are untrained is an unfortunate reality. For this reason, the large gaps which currently exist in aging research must be filled, and the number of adequately trained personnel in the field of gerontology must be expanded.

Federally Supported Aging Education and Research.

Administration on Aging -Title IV (OAA). The Title IV research, training, and demonstration programs, begun in 1966, are the only federally-supported programs designed to support applied research for the social/behavioral needs of older adults; to train personnel in non-health professions to work with the elderly; and to develop demonstration projects to serve as community models for service delivery programs for older Americans. The major programs currently funded under Title IV are research and demonstrations, gerontology training (including career preparation), training and demonstrations for legal service programs for the elderly, and support to national minority organizations.

Three examples of recently funded Title IV projects are: 1) The Hispanic Gerontology Internship Program which is sponsored by the Associacion Nacional Pro Personas Mayores. The program is designed to provide on-the-job and in-service training for hispanics by placing them in full-time administratively responsible positions in public and private aging networks. 2) Enhancing the Match of Gerontology Training and Employment Opportunities which is being conducted at the University of Southern California. The study will develop a model approach to the determination of manpower supply and demand and will apply this model to four national professional/paraprofessional fields. 3) Assessments of Gerontology Manpower through Current Graduates and their Employers which is being undertaken at the University of Utah. This project will survey graduates of gerontology programs and their employers. Job-related knowledge and skills as perceived by the graduates and their employers will be compared, as well as an evaluation of knowledge and skills needed for better job performance or advancement. This Association is a sub-contractor for both of these manpower studies. These three studies help to illustrate the wise investment of federal dollars in the long-range improvement of educational, research, and service delivery programs.

HRSA Bureau of Health Professions. The Bureau of Health Professions provides leadership in supporting the development and use of the nation's health personnel. Most of the programs of the Bureau are authorized by Titles VII and VIII of the Public Health Service Act. The most visible, identifiable geriatric components are found in the Special Educational Initiatives program (Section 788), which supports special high priority health professions projects of national importance. The program provides grant and contract support to health professions institutions, or other public or nonprofit private entities, for targeted health professions in a variety of priority areas. Students are trained to function effectively and efficiently as members of health care delivery teams and address both current and emerging health problems.

Included in the Special Educational Initiatives program are Geriatric

Education Centers (Section 788(d)). These centers are established to facilitate training in medical, dental, optometric, pharmacy, podiatric, nursing, and appropriate allied health and public health faculty, students, and practitioners in the diagnosis, treatment, and prevention of diseases and other health problems of the aged. In FY 1987, twenty-two of these regional resource centers were supported by BHP.

National Institute on Aging. Created in 1974, NIA has a legislative mandate "to conduct and support biomedical, social, and behavioral research and training related to the aging process and the diseases and other special problems and needs of the aged." Its current program emphases include preventing and treating Alzheimer's disease and other forms of dementia, lengthening life expectancy, maintaining health and functioning in later years, nutritional studies, and clinical medicine. NIA's research programs tend to be basic rather than applied, with strong emphasis on clinical and biomedical research, addressing health issues of special relevance for older persons. NIA's training programs have stressed discipline-based faculty training, particularly in the biomedical sciences.

At this time, AGHE is particularly concerned about the amount of funding allocated by NIA for social and behavioral research and training. Whereas the Behavioral and Social Research Program (BSR) has traditionally received 25 percent of the Institute's extramural research budget, the BSR program has been slated to receive only 22 percent of this budget in the future due to the creation of the Neuroscience and Neuropsychology of Aging Program. In fact, 25 percent of the Institute's extramural research budget has been targeted for this new program.

While AGHE fervently supports the efforts of biomedical research and training initiatives, we would like to stress the importance of social and psychological factors in affecting the quality of life of older Americans and the problems related to the aging process. Currently, the BSR program is considering issues of fundamental concern that include research on long-term care, the "oldest old," cognitive functioning, gender differences in aging, special populations, and international research which concerns the similarities and differences in health care risk factors across cultures. The BSR must continue to operate as a viable sponsor for these and other such research efforts.

NIMH Mental Disorders of the Aging Branch. Created in 1975, the Aging

Branch focuses on research, training and service related to mental health needs of America's older population. The research program of the Branch is divided into four general areas of support: Clinical research, treatment assessment studies, services research, and prevention and behavioral studies. Recent programs have concentrated on the causes, treatment, and prevention of Alzheimer's disease, senile dementia, and depression, psychopharmacology, alcohol and drug abuse, chronically mentally ill elderly, treatment intervention and service delivery models for the elderly.

Clinical training supported by the Aging Branch is concerned with the development of a caire of teacher/clinicians who will influence the training of professionals in the core mental health disciplines: Clinical psychology, psychiatry, psychiatric nursing, and social work. It is the major source of support for training clinicians with primary responsibility for the care of mentally ill older persons.

Administration's FY 1988 Budget Proposals and Their Impact.

AOA-Title IV. For FY 1988 the Administration has proposed a "generic appropriations request" for all social services sponsored by the Department of Health and Human Services. In addition to aging programs, the "generic request" will include Head Start, child welfare, developmental disabilities, child abuse and family violence, native American, and other social service programs. These programs would be funded at $2.2 billion which would result in an overall cut of $34 million. The implementation of this proposal would serve to effectively decimate the Title IV program which has been under continued scrutiny and attack by this Administration.

HRSA-Bureau of Health Professions. The Special Educational Initiatives in geriatrics was funded in FY 1987 at $10 million. The Administration has proposed to fund these programs at a level of $4.2 million in FY 1988. This would result in a reduction of 22 projects (from 36 to 14). Moreover, funds for geriatric and long-term care components included in other training programs of the Bureau would be drastically reduced from a sum of $17,017,467 in FY 1987, to $6,093,000 in FY 1988. As a result, most training programs in health professions outside of the Special Educational Initiatives (including those in geriatrics) would be discontinued.

National Institute on Aging. The FY 1987 budget for NIA was $177,017,000; the proposed FY 1988 budget is $167,164,000. If the President's proposed buget is enacted, the total number of funded research project grants would be reduced from 563 to 537. Similarly, the number of funded training grants would be reduced from 263 to 249.

NIMH Mental Disorders of the Aging Branch. The total clinical training budget for NIMH was $15 million in FY 1987. The Aging Branch received $1.8 million of this amount, allowing it to fund only 35 grants. Comparatively, in FY 1986, with an aging training budget of 2.8 million, 56 grants were funded. The Administration has requested $5 million for clinical training in FY 1988 for NIMH as a whole. At this level, the Aging Branch would have to cancel half of its 23 continuing obligations and fund no new projects. The future of the clinical training program at NIMH is in grave danger if budgetary cutbacks are allowed to continue.

On a more positive note, in FY 1987, the aging research budget was increased by 40 percent. This commitment to the study of mental health in the aging must be continued at its current level, and not reduced by 8 percent as the President has proposed.

Recommendations for FY 1988.

We are at a critical juncture in the development of resources and personnel required for an aging society. The size of the aging population is expanding so rapidly that this is not the time to curtail research or education efforts in this field. Rather, we must seize the moment by providing sufficient funding for aging education and research so that effective means can be developed to meet the needs of an increasingly "greying America."

With regards to NIA, this Association recommends an FY 1988, funding level of $236.8 million. This sum would enable the Institute to fund 60 percent of approved applications, instead of the current 35-38 percent. As a result, 331 competing research grants would be funded in FY 1988, instead of the 199 grants funded in FY 1987. Overall, the total number of competing and noncompeting grants would be increased from 563 to 693 in FY 1988. In addition, NIA would be able to fund 10 new Alzheimer Research Centers and provide 1.5 million for THA trials. Further, this increased funding level would allow NIA to provide greater support for behavior and social programs which can not be maintained without adequate funding.

This Association would also like to propose that the budget of the Federal Forum for Aging Related Statistics (within NIA), which serves as a coordinating body for a number of government agencies be increased by $50,000 to $550,000 in FY 1988. The data collected by this forum provides an invaluable tool to researchers and program planners in the field of aging.

The recommendation of this Association for Title IV (OAA) is a modest increase of 5 percent to $26,250,000. This small increment in the funding level would partially account for past inflation and serve to bolster the program. There has been no increase in Title IV funding since FY 1985. Whereas $25 million in FY 1985 provided for 32 gerontology training grants, the same sum of money allowed for only 21 training grants in FY 1986. We must reiterate our strong opposition to the notion of a generic appropriation for social services as the Administration has requested.

Recognizing the serious economic constraints under which this committee is operating, this Association strongly urges that the budgets of BHP and NIMH be maintained at a minimum at current services levels. We would like to stress the need to retain sufficient sums of money in the BHP budget for the continued operation of the Geriatric Education Center program.

Finally, we call upon Congress to appropriate funds for the systematic collection of manpower data in the field of aging. Congress has on several occasions requested from various agencies (AOA, HRSA, NIA) reports on future personnel needs for the field of aging. The reports which have so far been submitted to Congress on manpower reveal that there are considerable gaps in our knowledge. While the necessary questions regarding personnel needs are being posed, appropriate and valid answers can not be provided without funding for the development of an ongoing and coordinated data base that will provide manpower guidelines for the field of aging. The best use of federal, state, local, and private funds in the area of personnel training in the field of aging will only be made when current, comprehensive, valid, reliable manpower research is available.

STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES FOR TEACHER EDUCATION

Mr. Chairman and members of the committee, this testimony is presented on behalf of the American Association of Colleges for Teacher Education (AACTE) on the FY 1988 appropriations for educational research and statistics functions of the Department of Education.

AACTE is a national, voluntary organization of colleges and

universities that prepare the nation's teachers and other educational personnel. Its 725 nationally or regionally accredited institutions include small liberal arts colleges, state universities, and large research institutions. Combined, they graduate more than 85% of new personnel each year and serve the nation's teachers as their research and training arm.

Our membership has a great interest in a continued and improved federal investment in educational research, data gathering and dissemination. It is our institutions that are preparing the future teachers who will take the educational knowledge base to the nation's classrooms. Understandably, it is vital to us that the knowledge base be adequate, accurate and accessible.

Much attention and praise has been given to the assumption of fiscal and administrative responsiblity and the improved efficacy of educational services delivered by the states. However, one responsibility that remains beyond their resources and capabilities is the nationwide gathering and dissemination of information on education. More than a century ago, your predecessors in Congress assigned that task to the federal government. That mandate continues, and is now primarily assumed by the Office of Educational Research and Improvement (OERI) within the Department of Education.

Last year OERI was funded at $63.6 million, 24% less than in FY 1980. AACTE is urging the Congress to begin recovering this important lost ground. We firmly believe a renewed and improved commitment to educational research is a sound investment, and that a modest but responsible increase would assure and enhance the returns.

DEPARTMENT OF EDUCATION RESEARCH FUNCTIONS

Labs and Centers

The core of the research functions of the Department of Education is located in the university-based national research and development centers, and in the nine regional laboratories.

The university-based research and development centers are currently under a five-year contract funded at $17.8 million for FY 1987. Top qualified researchers have been gathered in these centers to apply their talents and acquired knowledge to scientific inquiry on nationally significant educational issues. Their successes include the development of enriched, useful information on effective schools, school leadership, compensatory education, and the acquisition of skills in reading, writing, language and mathematics.

The findings from the national centers are used by other researchers, policymakers, and, most importantly, educational practitioners. The centers work cooperatively with the regional laboratories to ensure that educational research is communicated and appropriately translated to the vital players in the improvement of educational practice.

The national network of regional education laboratories were also recompeted in 1985 and are funded at $17.2 million for FY 1987. These labs are assigned the task of identifying and meeting objectives in educational research and development for specific regions of the country. They provide technical assistance to all 50-states, the District of Columbia and the trust territories, working with their state agencies (SEAs), local districts (LEAs), school leadership, and classroom educators.

The nine labs work to make the national pool of education knowledge available and useful to their constituencies. They serve as liaisons among the SEAs, LEAs, universities, centers, and other education research producers and consumers. In addition, they are primary disseminators of research and development findings, providing the training materials and technical assistance to promote their effective use in the school setting.

AACTE asserts that our member institutions and the students they serve have been major benefactors of the services provided by the research and development centers and regional laboratories. We emphasize the contributions of the Center for Teacher Education, without discounting the importance of the other centers. In addition, we are encouraged by the recent OERI competition announcement for five new smaller research centers, and express particular interest in the Center for the Study of Teachers and Teaching in the School Context, and the Center for School Leadership, which will be funded in FY 1988.

We request that the Congress consider, at this time, the future expansion of the research and development centers and regional laboratories, increasing their number, and the scope of their activities. Their effectiveness is proven; expanded resources would ensure greater accessibility to their services and extend the benefits to a wider circle of constituents.

An example of such an expansion has recently been initiated in a rural schools project within OERI. AACTE is pleased by the action of the Congress to create a program to identify and support the development of promising rural and small school activities and practices. It is appropriate that the network of regional laboratories was identified as the vehicle for program design, synthesis and dissemination. We lend our support to the rural schools initiative, and will urge our member colleges and universities to work with the labs to develop and implement a series of models for rural education.

The $4 million seed money for the rural, small-schools project is an important beginning. We hope that the Congress and OERI will continue to acknowledge the significance of this activity and will move quickly to implement its initial phase. Furthermore, we ask you to extend this program so that its benefits reach more rural, small schools. Therefore, we suggest an appropriation of $12 million be used in FY 1988 to continue and expand this initiative.

ERIC

AACTE is proud to congratulate the Educational Resources Information Center on the occasion of its 20th year in operation. The nationwide information system currently has 16 clearinghouses with responsibility for acquiring significant educational literature in each of their particular areas of concern. Access to this information is then made available through computers, microfiche libraries, and printed indexes.

ERIC has prepared an interesting "fact sheet" that illustrates it status as the world's largest and most frequently used education data base. Excerpts show that more that 3000 institutions in the U.S. provide access to ERIC products, and there are more than 2.7 million users of ERIC resources annually. Each year the clearinghouses answer more than 100,000 inquiries. ERIC facilities and resources are used by state and federal governments, parents, researchers, professional organizations, college students, school boards, administrators, newspeople, and legislators.

Perhaps the most telling statistics on the ERIC system are these: 1) Elementary and secondary teachers are the most frequent users of ERIC; and, 2) For every federal dollar supporting ERIC, five additional dollars are spent by SEAs, LEAs, and colleges and universities to aquire and maintain ERIC resources and to enable users to gain access to ERIC information. That practitioners are the largest user group, and that the agencies delivering educational services are the major financial supporters of ERIC is clear indication of its value.

The ERIC System was funded at $5.8 million in FY 1987. That appropriation is representative of the level funding ERIC has received for the last five years. AACTE lauds the Congressional interest shown during the recent ERIC redesign conducted by OERI. With OERI, and the entire education community, we are committed to the highest quality research and most efficient delivery of usable information services. It is with these standards in mind that we encourage the Congress to increase funding for the ERIC system beyond the $6.1 million requested by the administration. Overall increases for ERIC for the purposes of broadened accessibility to improved services is an essential investment in improving the quality of education throughout America.

Smaller Grants

The national research and development centers, regional education laboritories and ERIC consititute the important nucleus of nationally significant education research and its application and dissemination. AACTE recognizes the need for longitudinal research and supports the 3-5 year length given to grants and contracts under these programs. However, because of the nature of these contracts, a decline in federal dollars assigned to educational research has meant that a greater percentage of funds have been obligated to these three major functions. As a result, a creative and dynamic force in educational research has been depleted, i.e. field-initiated research projects generated by individuals and smaller institutions.

OERI reports that more that 300 applications were received in 1986 for a combined $500,000 in grants. The high caliber of the proposals made choosing the ten awards a very difficult job. Able researchers with viable inquiries are numerous, but resources are needed to support their work. AACTE suggests that the Congress exceed the administration's request for a doubling of field-initiated studies in FY 1988.

Added to these small grants projects is a proposed $200,000 for awards to practicing teachers. The Teachers as Researchers Program recognizes outstanding professionals in the teaching field, and offers them the opportunity to develop innovative programs at the classroom level. Practitioner research on the use of educational tools, classroom management techniques and other means of improving professional skills is a fitting complement to the major research functions of the Department of Education. AACTE suggests that the Congress double the administration's request for FY 1988.

In addition, AACTE encourages increased monies for the Teacher Education Development Program. The Office of Programs for the Improvement of Practice currently maintains 29 university-based projects that "plan, implement, document and evaluate research-based improvement in teacher education programs". Fields of inquiry include: teacher induction programs, alternative teacher education models, teaching in the content areas, and technology as an educational tool. These 29 projects are designed to directly advance the improvement in the preparation of prospective teachers. Additional support would be useful for expanding their scope of study, and developing effective means of application to other institutions. To a major extent, the "second wave" of education reform has focused on teacher education and its objective of effective teaching. We suggest that a doubling of a federal effort in this arena is a moderate commitment to enhancing the profession.

A doubled commitment to these smaller projects amounts to a $4,000,000 appropriation from the Congress. The returns are guaranteed to be more than directly proportional to the investment.

STATISTICS FUNCTIONS OF THE DEPARTMENT OF EDUCATION

For three years, the American Association of Colleges for Teacher Education has collected data from the states on administrative and legislative initiatives in teacher education. This activity has proven that state education agency personnel are ready and willing sources of information. However, on some questions of significance to the national educational audience the states just do not have the answers.

For example, teacher supply/demand statistics of varying proportions are constantly cited, but hard, comprehensive data have been ellusive. With a teacher shortage at hand, state and local policymakers are in need of adequate information on which to base decisions regarding implementation of teacher recruitment and incentive plans. The collection of such information is a task of such proportions that its logical expediter is the federal government.

AACTE, therefore, fully supports the administration request for $21.6 million for the Center for Education Statistics (CES). OERI points out that this 53% increase over FY 1987 would "expand and upgrade the Center's collection, analysis and dissemination activities". A large portion of the funds would be directed to data collection on schools and school staffing. We assert that monies should also be used to gather comparitive data across all levels on such topics as teacher compensation and benefits, teacher workloads and non-instructional activities, and potential and actual minority representation in the teacher workforce.

These topics are of particular interest to AACTE, but CES collects and analyzes statistics on all aspects of American education. Precision and accessibility of information is an equally pressing need on topics relating to student achievement and progress, dropout rates, elementary/secondary longitudinal studies, and postsecondary education.

An adequate understanding of the condition of education in the U.S. today is fundamental to the effectual educational research and development which has formed the centerpiece of this request for appropriations. AACTE hopes that the Congress will also recognize the necessity of amplified support for the Center for Statistics.

CONCLUSION

AACTE's goal is to "provide...for continuous search for and promotion of ideas and practices which are most effective in the education of teachers and other school personnel." Consonant with this purpose is the major objective: "to stimulate and facilitate research, experimentation and evaluation in teacher education and in related problems of learning and teaching."

Based on this purpose, we reaffirm the initial tenet of this testimony, that the federal government is the primary supporter of educational research and development. Through the reauthorization and reorganization of the National Institute of Education to the Office of Educational Research and Improvement, the Congress has heard relevant testimony from legislators, state and local education officials, researchers and teachers. All have espoused the need for the federal conduct and support of educational research.

The challenges facing the American education system are added to daily. Great strides have been taken in the methodologies, outcomes and applications of educational research over the last decade, but we must continue to seek out the effective means to meet these additional challenges. To use a popular phrase, we must learn "what works" in TODAY's classroom, and apply that knowledge with immediacy.

AACTE takes this opportunity to thank the Congress for refusing to impose the debilitating cuts to education proposed in the President's Budget. The President's request for educational research activities within OERI amounts to one-half of one percent of his total request for education. AACTE's suggested budget marks, as delineated in this testimony, amount to slightly less than that fractional percentage when compared to both the current Senate and House budget numbers for education.

We urge the Congress to consider these numbers carefully, and press for their adoption. This small investment is the cornerstone to a sound education system, and that system services the richest asset of the nation.

STATEMENT OF LINDA FLORES, ACTING EXECUTIVE DIRECTOR, COUNCIL ON LEGAL EDUCATION OPPORTUNITY

On behalf of the Council on Legal Education Opportunity (CLEO), I submit this testimony regarding the appropriation of Assistance for Training in the Legal Profession, Title IX, Part D of the Higher Education Act of 1965, as amended, pursuant to which CLEO undertakes activities to assist individuals from disadvantaged backgrounds to obtain a legal education.

CLEO has been in operation since 1968. It was formed as a joint effort by the Association of American Law Schools (AALS), the American Bar Association (ABA), the National Bar Association (NBA), and the Law School Admission Council (LSAC), and in 1972 La Raza National Lawyers' Association (now the Hispanic National Bar Association (HNBA)) joined as a sponsoring organization. CLEO's programs were designed and continue to serve those educationally and economically disadvantaged persons who have had limited access to a legal education. While there is evidence that access to legal education has increased since 1968, in contrast to previous levels, access to graduate and professional opportunity by disadvantaged Americans continues to be an elusive goal. The goal of greater economic and political participation in the mainstream of society remains an unrealized dream for many: For example, the 1982 Annual Survey on Current Population Statistics of the Bureau of Census reports that of 606,000 lawyers in the United States, only 3.6% were members of a minority group. Currently, this percentage has increased to just over 4% of the more than 650,000 lawyers nationally.

The effort toward meaningful economic and political participation of minorities has been diligently pursued in higher education for very cogent reasons: higher education has proven to be a more effective vehicle than most for obtaining a more equitable distribution of political influence, simply because those persons most involved in the decision-making process of this country, are, themselves, products of the higher education system. This phenomenon is particularly germane to the legal profession given its role within the country's decision-making process generally and its historic lack of accessibility to minorities. The profession's impact on the formation of national policy is widely conceded because of the relationship of lawyers to all three branches of government, comprising almost exclusively the Judicial, and significant percentages of both the Legislative and Executive. It is this unique role played by the legal profession that raises compelling reasons for a continued emphasis on increasing the number of minority attorneys.

During the 1967-68 academic year, reliable statistics indicated the number of minority students enrolled in law school was as follows:

Blacks	1,245
Mexican American	180
Puerto Rican	69
Other Hispano Americans	81
American Indians	32
Total Minority Students Enrolled in Law School:	1,607

These numbers have improved significantly with regard to the 1985-1986 academic year as reflected in the Survey of Minority Group Students Enrolled in J.D. Programs in Approved Law Schools, 1985-86*:

Black American	6,051.5
Mexican American	1,635
Puerto Rican	412
Other Hispano Americans	1,632
American Indian or Alaskan Native	462.5
Asian or Pacific Islander	2,153
Total Minority:	12,346

When one considers the fact that between 1963 and 1985 the number of students in law school went from 46,666 to 118,700 and that the number of minority students enrolled in law schools has stabilized at 9% over the last five years, there is little doubt that the disparity which served as a catalyst for CLEO's inception in 1968, as yet, has not been sufficiently ameliorated to warrant the termination of the CLEO program.

The CLEO program works to increase the number of disadvantaged persons within the legal profession by providing an alternate mechanism for assessing, within the law school environment itself, the potential of each program participant for the study of law. Thus, the program is designed to serve those persons who aspire and are qualified to enter the legal profession but who may be unable to gain admission to law school through the traditional admission process.

The program achieves its goal of identifying qualified law school candidates and providing the opportunity for law school matriculation via pre-law academic summer institutes for prospective law students and the provision of annual fellowships.

The academic component of the Institutes is administered by seven (7) law schools located across the country,[1] sponsored jointly by CLEO and regional consortia of ABA-accredited law schools. The Institutes are based upon the premise that significant numbers of economically and educationally disadvantaged students

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*A Review of Legal Education in the United States, Fall 1985, Law Schools and Bar Admissions Requirements, (American Bar Association, 1986). Reproduced by permission of the American Bar Association, 1985.

**This classification refers to students reported as being members of a minority group but not identified further.

[1] The host law schools in 1986 were: the University of California-Berkeley; University of New Mexico; University of Missouri-Columbia; University of Wisconsin; Emory University; Dickinson School of Law; and, the University of Connecticut.

can be identified and prepared to successfully negotiate the law school curriculum. The Institutes mirror the law school experience by providing a six-week intensive study program in legal analysis and law development and emphasize abstract thinking, legal research and legal writing techniques. The Institutes are staffed by regular law faculty whose primary responsibility during the Institute is to evaluate each student's potential for successfully mastering the law school curriculum. Students who successfully demonstrate this potential are provided law school placement assistance and an annual stipend.

The CLEO Summer Institutes have been highly successful. To date, CLEO has helped 4,000 economically and educationally disadvantaged students to enter 160 accredited law schools throughout the country. Nearly 2,500 of these students have already graduated from law school and are now actively pursuing their careers in public service organizations, private law firms, government agencies and private industry.

CLEO has witnessed an overwhelming response to its program through the yearly number of applicants, and it is expected that this trend will continue. Last year (1985-86), sixteen hundred (1,600) students applied for 200 openings in the program, which attests to the continued credibility and viability of CLEO.

Data clearly demonstrates that CLEO Fellows have attained an impressive record of achievement by any measure, including performance within the academic arena of law school, bar performance, and most importantly, the employment activities of the program's graduates. The program has produced approximately 4,000 law school graduates involved in a broad spectrum of legal and law-related activities, including lawyers (public interest, private, corporate); judges; state representatives; law professors; executive administrators in various fields; Congressional staff, etc. The net result of the program has been increased access to the legal system and to the decision-making machinery of the country by those who have been disenfranchised for reason of race and/or economic status. Thus, the CLEO model of academic and financial support is one that works.

The continued success of the Summer Institutes, however, has been, to an increasing degree, dependent upon the generosity and largess of the law school community. Although authorization ceilings for the program have been set at $10 million dollars in previous years, the Legal Training for the Disadvantaged Program has received only one million dollars in appropriations since 1974; in Fiscal year 1985, the appropriation was modestly raised to $1.5 million dollars. This appropriation ceiling, in conjunction with the Gramm-Rudman-Hollings cutbacks in 1986, has limited the number of students that can be accommodated by the program and has placed a greater burden on participating law schools to cover increasing institute, tuition and living costs from their own financial resources.

Initially, the non-federal share represented between 30-40% of the total institute costs. However, over the last several years, the ever-spiralling costs of goods and services coupled with the effects of inflation, have thrust an even greater share of the Institutes' operating costs upon the law school. Given the fixed level of federal support, the law school community now absorbs approximately 60-70% of institute costs, as a demonstration of their commitment to the program. The law schools, without more federal assistance, cannot continue to maintain the academic institutes, while themselves facing reduced education budgets.

In addition, the law schools are asked to provide tuition scholarships, as well as other forms of financial support in recognition of the economic needs of the students served by the program. At a time when legal education is, itself, in a difficult fiscal situation, it is extremely important to realize that $1.5 million of annual federal support for this program generates as much as $3,000,000 in cash and services annually from the law schools. And, it is unlikely that these funds will continue to be forthcoming without the catalyst provided by the Legal Training for the Disadvantaged Program through CLEO.

Also, the ABA has for years been a principal contributor to the program in its dual capacity as one of CLEO's sponsoring organizations and administrative conduit for the funding from the federal government. The ABA contributes annually some $40,000 to the program's operation which rose to $62,000 in FY 1982 to address unanticipated financial obligations unmet by any other funding source. Additionally, CLEO has received funding and in-kind support from the Law School Admission Council (LSAC) to cover administrative costs of the program.

The financial component of the program is provided by way of annual fellowships. The provision of the stipend is contingent upon the satisfaction of several conditions: full-time enrollment at an ABA-accredited law school in the fall term immediately following participation in a Summer Institute, and the maintenance of "good standing" status throughout the duration of the grant. For the 1987 fiscal year, almost $1,000,000 will be provided by CLEO to disadvantaged students enrolled in law schools.

Cost of Law School Tuition, 1985-86:

	Median:	Average:
Public	$1,998.	$2,135.
Private	$8,042.	$8,286.

With the full cost (including room, board and tuition) for a student attending most law schools hovering around $10,000, the CLEO stipend, which was increased in 1985 from $1,000 to $1,750 and $1,600 for first year students and upper classes respectively, is hardly adequate and is well below the awards available from other graduate programs funded under Title IX. The total amount that a graduate/law student may borrow under the Graduate Student Loan Program is $25,000, which includes any loans made at the undergraduate level. The ALAS and PLUS loan programs allow graduate students to borrow $3,000 per year for a total of $15,000, and NDSL provides loans of $4,000 per year to a maximum of $12,000 for the combined undergraduate/graduate program of study.

The stipends, while inadequate, do provide a minimum of support for the needy students which the program services. Yet, even these amounts cannot be sustained in future years without additional appropriation. Other federally-funded graduate and professional programs, e.g., GPOP, Public Service and Mining Fellowships, have provided stipend assistance of approximately $6,000 per year and some have had institutional support components as well. This disparity in funding levels for students funded through similar federal programs under the same legislation has substantially hampered CLEO's ability to recruit students who would otherwise like to pursue a legal education. It was to correct this disparity in assistance, coupled with the program's impressive record of achievement, that encouraged Congress in 1980 to amend the Legal Training for the Disadvantaged Program legislation to provide new appropriation ceilings under the reauthorized Higher Education Act of 1965, as Amended.

The Program is cost-effective. While many programs have suffered substantial cost increases over the years, CLEO has been a rare exception. In the last eight

(8) years, the program has continued to service successfully its disadvantaged student population with only modest increase in cost to the federal government. Judicious cost-saving measures have been implemented over the past several years with an eye toward fiscal austerity, including executive staff salary freezes and significant reduction in program staff; once staffed by eleven employees, the program now operates with a staff of seven. A careful review of the program's budget already reveals a "bare-bones" operation.

The federal government has made a major commitment in the last decade to increasing educational opportunities for the poor and disadvantaged groups within society. This is an important commitment not only in terms of fairness, but also in terms of wise allocation of resources. Compared to many federal support programs, CLEO is impressive because the payoff is concrete, clear and quick. The modest federal support is matched several times by the substantial voluntary contributions of the law school community and is repaid to the government many times over in higher taxes from these individuals and in their service to society.

Observing the demonstrated success of CLEO participants and the continued support and cooperation of the nation's law schools, we request that you appropriate funds to legal training for the disadvantaged at the level of $2 million for FY 1988. This amount would permit CLEO to immediately increase student awards to approximately $2,000; even this level of support would not achieve parity for the program with grants being given by other Title IX programs.

In many ways, CLEO serves as a model of financial integrity. It is also an outstanding example of government partnership with the private sector in furtherance of significant social goals. For these reasons, the CLEO program merits ongoing support to continue its important and highly successful work.

LETTER FROM LEONARD BRITTON, SUPERINTENDENT OF SCHOOLS, DADE COUNTY PUBLIC SCHOOLS

May 1, 1987

Senator Lawton Chiles
SR-250 Russell Senate Office Building
Washington, D.C. 20510

Dear Lawton:

On April 27, 1987, I presented testimony before the House Subcommittee on Labor, Health, and Human Services and Education on the "Immediate and Long Range Impact of Nicaraguan Students on the Dade County Public Schools". I am enclosing a copy of that testimony.

I would appreciate it greatly your including these statements for the record as a part of the Senate Budget Hearings.

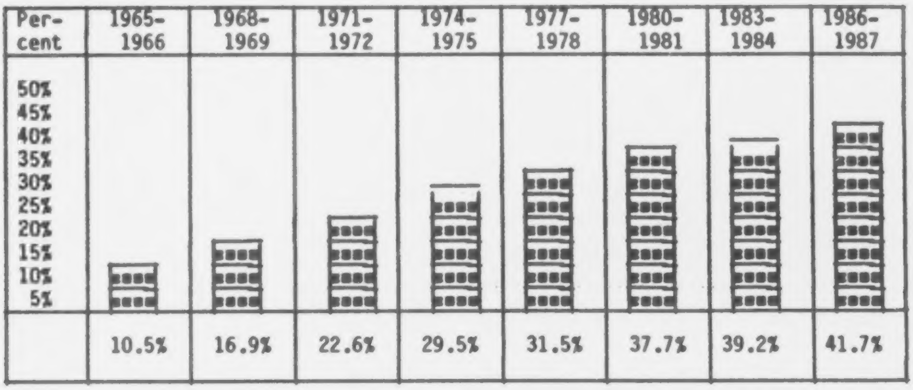
As always, we need your help in securing continued Targeted Assistance for the 1987-88 school year.

Sincerely yours,

Leonard

Leonard Britton
Superintendent of Schools

The Dade County Public Schools, the fourth largest school system in the nation, is a cosmopolitan school district which encompasses twenty-seven municipalities and townships, and a large unincorporated area. It serves a diversity of ethnic and racial groups in school communities ranging from highly urbanized to agricultural. As evidenced by the chart below, there has been a dramatic change in the ethnic composition of the student population, from 10.5% Hispanic in 1965-66 to 41.7% Hispanic in 1986-87.



Among the Hispanic origin students in the Dade County Public Schools, those of Cuban origin represent the large majority. However, there are substantial numbers of other Hispanic origin students, such as Mexican-Americans, Puerto Ricans, and a relatively new group, the Nicaraguans. Nicaraguan students first began to enter the Dade County Public Schools in significant numbers in 1980, about the same time as the Mariel "boatlift". The annual influx of such students since that time is reflected in the following summary:

1980-81	1982-83	1984-85	First Eight Months of 1986-87
748	875	1,138	1,560

It is significant to note that during each month of the current school year, the number of new Nicaraguans has exceeded the number of new Cubans, averaging 195 Nicaraguans per month as opposed to 120 Cubans per month.

Our records indicate that since 1978, some 12,566 Nicaraguan-born students have entered the Dade County Public Schools. Of these 12,566 Nicaraguans, 3,009 are no longer in the school system, leaving 9,557 which we are still serving. Over 5,600 are in elementary schools, nearly 2,500 are in middle/junior high schools, and over 1,400 are in senior high schools.

As of March 6, 1987, Nicaraguan students were attending 161 of our 180 elementary schools. Thus over 89% of such schools have been impacted by the Nicaraguan influx. At the middle/junior high level, Nicaraguan students were attending 45 of our 47 schools (nearly 96%) at this level. At the next level, all 24 of our senior high schools have been impacted by Nicaraguan students.

Although our Nicaraguan students are widely distributed throughout the school system, some 64% are concentrated in the South Central Area, one of four administrative areas in Dade County. The other students are divided more or less equally among the remaining three administrative areas.

Our most recently completed elementary school which is now fully operational is Sweetwater, which is in the South Central Area. The school has a building capacity of 855 students. By mid-March, however, student membership exceeded 1,300. One out of every four of these students was born in Nicaragua, and new Nicaraguan students continue to enter on a daily basis. Of the Nicaraguan students in Sweetwater Elementary, 65% are classified as limited English proficient and at an ESOL function level which does not permit them to benefit from the regular curriculum when taught solely in English.

The more than 5,600 Nicaraguan students in elementary grades are enough to fill 6.6 schools such as Sweetwater. The nearly 2,500 Nicaraguan students in middle/junior high grades would tax the building capacity of one typical junior high school and almost fill a second. If we were to open a new senior high school tomorrow, 70% of the space could be filled by Nicaraguan students.

In terms of capital outlay costs, these statistics have tremendous implications for the Dade County Public Schools. The cost of providing student stations for the Nicaraguan students may be summarized as follows:

Elementary = $7,345 per student x 5,627 students = $41,330,315

Middle/Junior = $9,026 per student x 2,485 students = $22,429,610

Senior =$14,238 per student x 1,445 students = $20,573,910

All Levels 9,557 students = $84,333,835

In the early 1980's, the school system was more able to respond to facilities needs because we were in a period of declining enrollments. However, during the five-year period 1982-83 to 1986-87, student membership in the Dade County Public Schools has grown from 222,058 to 244,734, an increase of 22,676. For 1987-88, we are expecting an opening-of-school membership of 253,900, representing an increase of 9,166 during a single year.

Although the basic thrust of this testimony has to do with Nicaraguan students because of the intensity and duration of their impact - 1,560 in eight months- it should be noted that new refugee registrations from all sources during the first eight months of 1986-87 was 2,583, averaging 323 per month. It is equally important to note that during this same eight month period, the number of undocumented foreign born students almost equaled the refugee students (2,521 undocumented versus 2,583 refugees). The total of foreign born registrations in all categories during this eight month period was 7,208, averaging 901 per month, and representing more than enough to fill one new elementary school per month. These 7,208 students fall into the following categories:

I-20* I-538**	Other Non-residents	Refugees	Undocumented	Total
1,410	694	2,583	2,521	7,208

* INS form used to secure student visa

** INS form used for transfer or to renew student visa

Inherent capital outlay costs, which are staggering, are indeed a major problem, but not the only one. Once the students have been housed, we must get on to other types of concern a school system must face when it is called on to serve large numbers of refugee-type students who enter this country within a relatively short period of time. These include:

1) Direct supplementary instruction, including provision for English for Speakers of Other Language, and necessary instruction in and through the home language while the students are learning English

2) Instructional support services, including services of bilingual counselors, visiting teachers, and psychologists

3) Transportation required by law, following established distance-from-school guidelines

4) Custodial, maintenance, and operational support, including utilities.

Many of the per pupil costs in the service categories mentioned above can be linked in some measure to State funding through the Florida Education Finance Program (FEFP). For example, English for Speakers of Other Languages, as part of Alternative Education, carries a special weighting to help offset the cost of program delivery. Instructional support services, transportation, and operational support can also be linked directly or indirectly to State funding. One major category which cannot be so linked is providing direct supplementary instruction in and through the home language while the students are learning English.

Supplementary instruction in and through the home language in Dade County is referred to as the program of Basic Skills in the Home Language. This program consists of two parts: (1) Home Language Arts, and (2) Curriculum Content in the Home Language.

> Home Language Arts is designed to facilitate in the home language the acquisition and reinforcement of communication skills which are part of the English language arts curriculum.
>
> Curriculum Content in the Home Language is designed to facilitate in the

home language selected basic skills and concepts which are generally offered only in English. It implements in Social Studies, Science and Mathematics the same instructional objectives that are implemented in the regular curriculum in English. This home language support is phased out as the students gain proficiency in English.

Since the new Nicaraguan students who are limited English proficient have educational needs that are somewhat different from those of native-English speaking students, it is important that their special needs be identified and that the necessary provision be made for meeting them at instructional and psychological levels. The first educational need of these new Nicaraguan students is to acquire the ability to communicate in English, that is, to speak and understand English in the school setting. This includes developing competency both in the type of English needed for social interaction and the type of English needed for successful participation in the formal curriculum.

It is assumed that most students entering the Dade County Public Schools with little or no English will normally require from one to three years to learn English well enough to complete in English the regular work of the grade in which they belong. In general the Nicaraguan students will present the same range of academic and emotional problems as English language origin students. In addition, at any given point these students will reflect a range of differences in growth of receptive use of language - listening and reading, and of productive use of language - speaking and writing.

The Nicaraguan students entering the United States present a special problem resulting from interrupted or otherwise limited prior school experience. As socio-political unrest continues in their homeland, the gap between prior school experience and expectancies in American schools will continue to widen and make the transition to an English speaking school environment more difficult.

Viewing the Nicaraguan students' progress overall, it appears that for a significant number the normal 2 to 3 year span of special language instruction required for most limited English proficient students has become a 3 to 4 year span for such instruction. Other types of programs, such as Basic Skills in the Home Language, and other services, such as bilingual counselors, visiting teachers, and psychologists, will also probably be required for longer periods of time for new Nicaraguans than for other limited English proficient students whose prior academic experiences are more comparable to those of English language origin students in the United States.

Our preliminary 1987-88 budget projections for delivering Basic Skills in the Home Language at the elementary level total $6,983,022. To provide such instruction for our foreign born students at the secondary level would add significantly to the cost - conservatively an additional $500,000 to $600,000 - placing a total direct cost of instruction at ± $7.5 million.

As of March 25, 1987, our fiscal forecast for 1987-88 has estimated a $65.9 million deficit, if the Governor's Budget is approved by the State Legislature and if the Continuation Budget expenditure requirements occur. We are faced with the problem of attempting to provide Nicaraguan and other foreign born students, who are in our midst as the result of Federal policies, the kinds of instructional programs which they require if they are to make a smooth and rapid transition into the academic mainstream. This comes in direct conflict with our efforts to provide adequate programs for the other quarter million students we must serve.

In light of our current fiscal crisis, brought on in large measure by a constant renewal of refugee groups, and in light of the turmoil and prolonged instability in Central America, we turn to Congress and the Federal Government to help support the efforts of local school districts in meeting the needs of refugee students, who are a direct product of Federal policy. This type of support should take into consideration both the immediate needs inherent in providing a transitional instructional program while the students are learning English, and the long term capital outlay needs inherent in uncontrolled expansion of our student population.

The Dade County Public Schools is deeply appreciative of the support which has been provided at the national level to help it meet the serious crises it has had to face and continues to face with respect to educational services for refugee children. It would be difficult to imagine how the school system

could have responded to these crises without such support. At the same time, the Dade County Public Schools is equally hopeful that the extent of the continuing national obligation will be addressed in realistic terms.

The numbers of new refugee students is in some measure predictable, based on influx data covering foreign born registrations. There are, however, many unpredictable dimensions of new immigration and what steps might be necessary to respond to the special needs of school-age children in such a population. The Dade County Public Schools urges the Federal Government to provide adequate resources to support its immigration policies, and to establish mechanisms to facilitate the flow of these resources to the points of need at the time of need.

STATEMENT OF DANIEL W. MERENDA, EXECUTIVE DIRECTOR, NATIONAL SCHOOL VOLUNTEER PROGRAM, INC.

It is a pleasure to have an opportunity to talk about parent-citizen involvement in education and to talk about the National School Volunteer Program and the role that it has been playing in promoting an advocating parent-citizen involvement in education.

The National School Volunteer Program is a nonprofit education association headquartered in Alexandria, VA. Our mission is to strengthen the partnerships between educators and citizens on behalf of students. What we do is assist school systems in recruiting, training and placing volunteers in public schools. Our national membership stands at approximately 5,000 members, and represents 46 States, Canada and the U.S. territories.

A substantial number of our members are directors of school volunteer programs. They are full-time paid staff within school districts. They coordinate an impressive number of volunteers in almost every urban school system in the country, and in many surburban and many rural school districts as well. In New York City, for example, there are 25,000 volunteers providing remedial tutoring and math services to students in the classrooms. They work one-on-one with the gifted and with the handicapped. They provide teachers with more time to teach by doing classroom management tasks such as filing, grading tests, and things of that nature.

In Houston, Texas--where volunteers participate in all of the district's 168 elementary schools and most of the district's secondary schools--there are 14,000 volunteers contributing over 400,000 hours of service.

The State of Florida documents 117,000 volunteers currently providing services to children in schools throughout their state.

Here in the District of Columbia, some 17,000 volunteers help children to a better education by serving as mentors, role models, armchair historians, tutors, and guest speakers.

In Los Angeles where seniors are tapped as a major resource, there are some 24,000 volunteers currently providing services.

The San Francisco California School Volunteer Program reports some 1,700 volunteers who give an average of between 2 and 10 hours per week.

Nationally, there are some 4.3 million citizens freely volunteering their time, talents and skills in our public schools--33 percent of this number are parents, another 24 percent older citizens, another 21 percent are students, and an impressive 18 percent are representatives of the business community. Today, volunteers are serving in 79 percent of our public schools.

Volunteer programs, contrary to public opinion, are not free. They do cost money. We found in our survey that the average expenditure by school districts in 1982 was $11,000. Of the money spent, some 30 percent comes from the private sector, and another 70 percent from public taxes. The rate on the return of that investment is a phenomenal 50 to 1.

To have a successful program, we have learned that there are some necessary common factors. Those factors, quite briefly, are:

- **A stong support system.** We found that in school districts where there is strong district-level support--that is, where the board of education or the superintendent vocalize their support and provide line-item budget support--the programs seem to be more stable and more successful.
- **A Written policy.** A formal written policy submitted to the board and adopted by the board of education supporting the program and outlining requirements, requirements such as volunteers working under the supervision of paid staff.
- **A systemwide manager.** Volunteer programs, are as difficult to manage as any other program operating within school systems. There is a concept that if you are talking about a parent involvement program or a volunteer program, that somehow the programs will run themselves. That is not true. You need a full-time manager, someone who has those kinds of skills, to make the program work.
- **Building level managers** at the school building level. An individual to be designated by the principal to manage the program--not necessarily a paid staff, but someone who is going to be responsible for organizing.
- **People.** Volunteer programs focus on involving people, not procuring money. The annual Gallup poll of the public attitudes toward public schools repeatedly shows that people are more supportive of social institutions with which they have direct contact and involvement. The volunteer program is an avenue of involvement into the public schools, a way of letting not only parents play a substantive role in the instruction of their children, but a way of getting those involved who otherwise have no direct contact with the public shcools, those seniors, those business people who only read about the things that are happening in education.

Volunteer programs are successful when options are provided for volunteers. People need choices. Not everyone wants to be a classroom assistant. If you are bringing in a business person who is a computer expert, that person may well not want to tutor on a one-to-one basis. That person may, however, be someone who could assist the principal in school management.

We found that collaboration and long-range planning is a necessity in parent involvement and volunteer programs. All of those individuals who are attracted by the program need to be involved in the planning--that includes teachers and volunteers.

But the results of careful volunteer program planning and organization are worthwhile. In 1975 the Dade County, Florida Public Schools conducted a study (supported by the U.S. Office of Education) which centered on student performance in grades 2-6 in reading and mathematics. Students assisted by volunteer tutors were compared with unaided students. The findings: in both subjects, the tutored students did remarkably better than their untutored classmates. In reading, tutored students' mean gain in grade equivalent exceeded a full grade (1.02) while those without tutoring performed only 4% as well (0.38). In mathematics, the tutored group's mean gain was 81% of a grade level compared with an actual decline of 6% for the untutored. Better yet, the Dade County researchers concluded, the financial costs of the school volunteer project were "Minimal compared to the return on investment."

On a broader basis, the results of the findings indicated that volunteers have much to offer beyond simply increasing human interaction levels, that they can play a substantive academic role in improving the quality of education.

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